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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

SHEILA DAVIDSON, individually and on behalf of all others similarly situated;

Plaintiff,

v.

CIGNA HEALTH AND LIFE INSURANCE COMPANY; CIGNA HEALTHCARE OF CALIFORNIA, INC.; and DOES 1 through 100 inclusive,

Defendants.

Case No.: BC558566

CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL

1. Violation of Business & Professions Code § 17200, et seq. (Unlawful)
2. Violation of Business & Professions Code § 17200, et seq. (Unfair)
3. Violation of Business & Professions Code § 17200, et seq. (Fraudulent)
4. Violation of False Advertising Law, Business & Professions Code § 17500, et seq.
5. Violation of the Consumers Legal Remedies Act, Civil Code § 1750, et seq.
6. Breach of Contract
7. Breach of the Implied Covenant of Good

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Faith and Fair Dealing
8. Declaratory Relief

Plaintiff Sheila Davidson (hereinafter, "Plaintiff"), on behalf of herself and all others similarly situated, brings this action against defendants Cigna Life and Health Insurance Company and Cigna Healthcare of California, Inc. (hereinafter, collectively "Cigna"). Plaintiff alleges the following on information and belief, except as to those allegations that pertain to the named Plaintiff, which are alleged on personal knowledge:

NATURE OF THE ACTION

1. Plaintiff brings this action to challenge Cigna'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, Cigna:

- Misrepresented, and continues to misrepresent, to consumers that their physicians and hospitals are participating in Cigna health service plans; and
- Subjected, and continues to subject, Plaintiff and Class Members to inadequate networks of physicians and hospitals, causing delays and interruptions in accessing needed health care.

2. As of January 1, 2014, to coincide with the commencement of federal health reform, the Affordable Care Act (hereinafter, "ACA"), Cigna began offering new individual health service plans to California consumers.

3. The new ACA-compliant plans were made available to consumers during a designated enrollment period between October 1, 2013 and March 31, 2014 (hereinafter, "Open Enrollment Period").

4. Cigna represented and marketed, including on its public website, its health service plans as having specific physicians and hospitals ("providers") available to consumers enrolled in those plans (hereinafter, "provider networks"). Plaintiff and Class Members

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checked with Cigna over the phone, on Cigna's website, and with their providers to make sure that their providers were in-network under their Cigna health plan. In response to consumer inquiries, Cigna also emailed lists of in-network providers to Plaintiff and Class Members. Class Members purchased plans and visited providers in reliance on Cigna's misrepresentations and omissions regarding provider networks.

5. In general, Cigna's health plans allow enrollees to visit pre-specified, in-network providers at a discount, but also cover some portion of out-of-network provider services. 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 Cigna and in-network providers. Patients who receive services from out-of-network providers must meet a separate, often much higher, out-of-network deductible and do not benefit from the negotiated fee schedules in place for in-network providers. Additionally, payments to out-of-network providers do not accrue toward an enrollee's statutorily set out-of-pocket maximum.

6. During the Open Enrollment Period, Cigna only offered PPO plans directly to California consumers and did not sell its plans through the State's exchange, Covered California. Despite only selling its plans outside Covered California, and thereby avoiding the additional regulations and oversight associated with the exchange, Cigna misleadingly referred to its plans by names such as "Covered California Silver Coinsurance Plan."

7. Due to Cigna's actions and misrepresentations, Plaintiff 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 do not accrue toward Plaintiff's and Class Members' annual in-network deductible;
- Payments made to out-of-network providers do not accrue toward Plaintiff's and Class Members' annual out-of-pocket limit; and,

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- PPO plans impose much higher deductibles for out-of-network providers.

8. In fact, leading up to January 1, 2014, Cigna greatly reduced its network of physicians and hospitals.

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

10. Furthermore, Cigna had a clear incentive to represent out-of-network providers as in-network. Relying on Cigna's misrepresentations and omissions, Plaintiff and Class Members did not discover that providers were out-of-network until after visiting the provider and incurring charges. As a result, Cigna significantly decreased the amount it reimbursed for health care treatments and services, leaving Plaintiff and Class Members to pay the remainder.

11. Plaintiff brings this action on behalf of herself and on behalf of a class of current California residents who are currently enrolled in, or who were enrolled in, a Cigna individual health service plan contract purchased after October 1, 2013 (the "Class").

12. Cigna's unlawful, unfair, and fraudulent conduct violates California Business and Professions Code sections 17200, et seq. and 17500, et seq.

13. Cigna's bait and switch tactics of representing and advertising that its health 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.

14. Finally, through its conduct of misrepresenting provider networks and failing to provide proof of insurance to consumers, Cigna has breached the individual health service plan contracts entered into with Plaintiff and Class Members and breached the implied

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covenant of good faith and fair dealing.

15. Plaintiff seeks an order of this Court enjoining Cigna's continued violations of law and declaratory relief as set forth herein. Plaintiff also seeks restitution of monies collected from Class Members in violation of California law, and any other remedies as set forth herein to the fullest extent permitted by law.

PARTIES

16. Plaintiff Sheila Davidson (Davidson) is a citizen of California and resides in Orange County.

17. Defendant Cigna Health and Life Insurance Company is a corporation duly organized and existing under the laws of Connecticut with its principal place of business located in Bloomfield, Connecticut and is authorized to transact, and is transacting, the business of providing health coverage in California.

18. Defendant Cigna Healthcare of California, Inc. is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in Glendale, California. It is authorized to transact and is transacting the business of providing health coverage in California.

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

20. At all relevant times, Cigna 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

21. This Court has jurisdiction over this action under Article VI, section 10 of the

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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.

22. This Court has jurisdiction over Cigna.

23. Defendant Cigna Healthcare of California, Inc. is a resident of the State of California.

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

25. Plaintiff does 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.

26. Venue is proper in this Court because, inter alia, Cigna engages and performs business activities in the County of Los Angeles and many Class Members entered into agreements to purchase Cigna's health plans while in the County of Los Angeles.

STATUTORY AND REGULATORY SCHEME

27. 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.) Individuals could purchase health service plans through their state's exchange or directly from insurers 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).)

28. 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. §

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18041(d).) State laws that impose stricter requirements on health service plan issuers than those imposed by the ACA are not superseded by the ACA.

29. Plaintiff's and Class Members' individual health plans are subject to the requirements of California Insurance Code. Some Class Members' plans are subject to the requirements of California Health and Safety Code sections 1340 through 1399.99.

30. 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, regulations promulgated pursuant to the Insurance Code require that advertisements for health plans "shall be truthful and not misleading in fact or in implication." (Cal. Code Regs. Title 10 ["10 CCR"] § 2536.1(b).)

31. Insurance Code sections 10603 and 10604 require health plans to "provide, in easily understood language and in a uniform, clearly organized manner" information including the "principal benefits and coverage of the disability insurance policy" and the "exceptions, reductions, and limitations that apply to such policy."

32. Insurance Code section 10133.5 provides "that insureds have opportunity to access needed health care services in a timely manner" . . . "to assure accessibility of provider services in a *timely manner* to individuals . . . pursuant to benefits covered under the policy or contract." (*Id.* at (a) and (b), emphasis added.) The purpose of the statute is to ensure, among other things, that:

- "The policy or contract is not inconsistent with standards of *good health care and clinically appropriate care*." (Ins. Code § 10133.5(b)(3), emphasis added.)
- "All contracts including contracts with providers, and other persons furnishing services, or facilities shall be *fair and reasonable*." (Ins. Code § 10133.5(b)(4), emphasis added.)

33. Regulations promulgated pursuant to Insurance Code section 10133.5 require that "insurers shall ensure that … [n]etwork providers are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the health care services

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covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services." (10 CCR § 2240.1(b)(1).)

34. Insurance Code section 10133.56 similarly allows consumers who are in the course of treatment to continue to receive treatment from their provider of choice, even after the health insurer terminates its contract with the provider:

- (a)(1) A health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133 shall, at the request of an insured, arrange for the completion of covered services by a terminated provider, if the insured is undergoing a course of treatment for any of the following conditions:
- (A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- (B) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.
- (C) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate

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postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

- (D) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new insured.
- (E) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

FACTUAL ALLEGATIONS

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

35. As of January 1, 2014, to coincide with the commencement of the ACA, Cigna began offering new ACA-compliant individual health service plans to California consumers.

36. The new ACA-compliant plans were made available to consumers during the Open Enrollment Period, between October 1, 2013 and March 31, 2014.

37. During the Open Enrollment Period, Cigna only offered PPO plans directly to California consumers and did not sell its plans through the State's exchange, Covered California.

38. Millions of Californians went shopping for new health plans during the Open Enrollment Period. In an effort to increase its share of the California individual health service plan market, Cigna engaged in a fraudulent and deceptive marketing scheme leading up to, and during, the Open Enrollment Period.

39. Despite only selling its plans outside Covered California, and thereby avoiding the additional regulations and oversight associated with the exchange, Cigna misleadingly

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referred to its plans by names such as "Covered California Silver Coinsurance Plan." The Attorney General ordered Cigna to stop using the "Covered California" label in the names of its plans because it was misleading to consumers.[1]

40. Also, at all relevant times, Cigna's website offered, and continues to offer, users a feature that allows them to search Cigna's network of providers and view and email themselves lists of in-network physicians. Cigna also allows consumers to obtain provider network information over the phone from its customer service agents.

41. Plaintiff alleges upon information and belief that Cigna 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.

42. The network of Cigna providers available to Plaintiff and Class Members is drastically more limited than represented by Cigna. Cigna 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. Cigna knew that many potential customers would check to ensure that certain providers were listed as in Cigna's network before selecting a new ACA-compliant plan. Therefore, Cigna intentionally disseminated an inaccurate provider list to 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 Cigna's network.

43. Thousands of enrollees are now finding out for the first time that they were provided inaccurate information, either over the phone, or on Cigna's website. As a result, many 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,

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[1] Chad Terhune, *State tells Cigna to Stop using Covered California Exchange Name*, Los Angeles Times, Jan. 13, 2014, http://articles.latimes.com/2014/jan/13/business/la-fi-mo-cigna-covered-california-20140110.

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reduced networks.

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

B. Sheila Davidson was fraudulently induced into purchasing a Cigna health plan with a drastically reduced network of providers.

45. Sheila Davidson is a 61-year-old woman who suffers from a cascading history of medical problems, including pelvic inflammatory disease, pelvic floor tension myalgia, and peritonitis. Essentially, scar tissue has twisted and wrapped around Sheila's organs, causing her tremendous pain and preventing her body from processing food. Without continual treatment to loosen the scar tissue, Sheila would not be able to live.

46. Sheila's condition is unique. There has only been one team of specialists that has been able to successfully understand and treat Sheila's peculiar combination of medical issues. For years, Sheila has been seeing Dr. Richard Kempart, her primary physician, and a team of specialists at the Women's Center at University of California Irvine ("UCI") Medical Center. The UCI team includes Dr. Karen Noblett, Dr. Felicia Lane, Dr. Stephanie Jacobs, and a physical therapist, Patti Nygai.

47. In late 2013, Sheila's health insurer at the time, Anthem Blue Cross, cancelled her policy. Sheila had to be particularly careful in choosing a new policy, as she was in a precarious financial and medical situation. Years before, her husband suffered a stroke and lost his business. Her daughter has also been diagnosed with a disability. The resulting medical bills forced Sheila to sell her home.

48. Looking for a policy that covered her team of specialists, Sheila eventually found Cigna. Using the Cigna website, she entered each of her doctor's names and addresses, and all of her doctors were covered in the plan she chose: myCigna Health Flex 2750 Silver

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PPO plan. Although Cigna later took this information down from its website, Sheila printed off each page indicating that each doctor was covered in the plan. Sheila also called Cigna to confirm that her doctors were in-network. The Cigna agent informed Sheila that if the website listed her doctors as in-network then they would be covered under her plan. Cigna also provided Sheila with a booklet that promised continuity of care.

49. The premium for this PPO plan was $729.82 per month, with an in-network deductible of $2,750 and an out-of-pocket limit of $6,350. The out-of-network deductible and out-of-pocket limit were significantly higher, $12,500 and $25,000, respectively.

50. Relying on Cigna's representations about coverage and continuity of care, Sheila purchased the plan, which became effective on January 1, 2014.

51. Sheila continued treatment with her team of physicians in early 2014. When she received the EOBs for her treatments, the EOBs confirmed that her doctors were covered and she was responsible for paying the "in-network" rate for those treatments.

52. In May, 2014, Sheila's condition worsened. Her weight dropped to 80 pounds and she would faint from her body's inability to process food. On May 7, 2014, Cigna authorized an in-network Peripherally Inserted Central Catheter (PICC) line treatment that saved Sheila's life.

53. A week later, however, as Sheila was about to meet her $6,350 out-of-pocket limit, she received a bill from Cigna charging her for the entire cost of the May 2014 treatment. Although Cigna never gave Sheila any prior notice or explanation, it unilaterally changed all of her doctors to out-of-network status. Now, in her most vulnerable medical state, Sheila had to pay for her entire treatment, even though Cigna's website and previous billings had confirmed that those treatments were covered.

54. When Sheila called Cigna to fix the problem, they simply told her that the original coverage for her doctors was a "mistake."

55. Sheila's health plan offers considerably less coverage for out-of-network services. First, Sheila's plan's out-of-network deductible, $12,500, is much higher than the in-

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network deductible, $2,750. Therefore, Sheila must pay $12,500 more out-of-pocket before Cigna contributes *any* amount toward her care. Second, even if Sheila meets her $12,500 out-of-network deductible, Cigna will only pay 50% of the cost of care up to the "Maximum Reimbursable Charge," above which Cigna will pay nothing. This significantly reduces the percentage of the total cost that Cigna will reimburse. Practically, this means that Sheila will pay far more than $12,500 before Cigna will cover any of her "out-of-network" care. In comparison, on an in-network basis, the entire cost of services accrue toward Sheila's deductible, the deductible is much lower (thus requiring Sheila to pay less out-of-pocket before Cigna contributes toward her care), and, once Sheila meets her in-network deductible, Cigna pays the entire cost of care.

56. On June 19, 2014, Sheila filed an urgent appeal with Cigna, requesting that it continue to treat her doctors as in-network, as promised. Cigna misplaced the appeal and Sheila had to personally track it down and make sure it was sent to the right department within Cigna. Cigna has still not responded.

57. Sheila continues to pay out-of-pocket for coverage that is significantly less than what was promised by Cigna. Sheila has no option to stop treatment with her team of physicians as it is required to keep her alive. Cigna's network also does not offer other doctors that can treat her complicated condition. Sheila cannot switch insurers until the next enrollment period in November. She continues to pay the $729.82 monthly premiums for coverage that is significantly different that what was represented to her. Sheila has also been forced to pay more than $2,700.00 out-of-pocket and continues to incur large amounts of additional expenses that should have been covered as in-network under her Cigna plan.

58. Cigna's wrongful denial of benefits has taken a severe toll on Sheila's medical, financial, and emotional state at a time when she most needs the protection of her health plan. Sheila is now fearful of using her Cigna plan and has suffered unwarranted delays and changes in care due to Cigna's conduct.

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SUMMARY OF CIGNA'S ILLEGAL ACTS

59. As discussed in more detail herein, through its conduct of misrepresenting provider networks, Cigna:

- Violated 10 CCR § 2536.1(b), which requires that advertisements for health service plans "shall be truthful and not misleading in fact or in implication."

- Violated Insurance Code sections 10603 and 10604, which require health plans to "provide, in easily understood language . . . and in a uniform, clearly organized manner" information including the "principal benefits and coverage of the disability insurance policy" and the "exceptions, reductions, and limitations that apply to such policy."

- Violated insurance Code section 10133.5, which requires that policies and contracts with Class Members are "fair and reasonable" and "not inconsistent with standards of *good health care and clinically appropriate care*." (Emphasis added.)

- Violated regulations promulgated pursuant to Insurance Code section 10133.5, which require that "insurers shall ensure that … [n]etwork providers are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services." (10 CCR § 2240.1(b)(1).)

- Violated Insurance Code section 10133.56, 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.

60. Cigna engaged in various unfair and deceptive acts in violation of the CLRA by:

- Representing health plans as having certain providers in-network 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 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 plans provide coverage for services rendered by a network of certain providers and then refusing to reimburse care from

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that network of providers in violation of Civil Code section 1770, subdivision (a)(14).

- Adopting unconscionable contract provisions adopting inadequate provider networks, and concealing material terms of the coverage in violation of Civil Code section 1770, subdivision (a)(19).

CLASS ALLEGATIONS

61. This is brought on behalf of the Plaintiff individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382 and Civil Code section 1781. Plaintiff seeks to represent the following class:

> All current California residents who enrolled in an individual Cigna health service plan after October 1, 2013.

62. Plaintiff reserves 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.

63. 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 Plaintiff but can be obtained from Cigna's records.

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

65. Plaintiff is a member of the Class and Plaintiff's claims are typical of the claims of the Class.

66. Plaintiff is willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiff will fairly and adequately protect the interests of the Class and has no interests adverse to or which conflict with the interests of the other members of the Class.

67. The self-interest of Plaintiff is co-extensive with and not antagonistic to those of absent Class members. Plaintiff will undertake to represent and protect the interests of absent Class members.

68. Plaintiff has engaged the services of counsel indicated below who are

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experienced in complex class litigation, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent Plaintiff and absent Class Members.

69. 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 Cigna.

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

71. 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.

72. Plaintiff does not anticipate any unusual or difficult management problems with the pursuit of this Complaint as a class action.

FIRST CAUSE OF ACTION

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

Unlawful Business Acts and Practices

73. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

74. 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 . . . ."

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

76. Cigna 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 Insurance Code, California Code of Regulations, and the CLRA as follows:

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a. By misrepresenting the providers that would be in-network under Plaintiff's and Class Members' plans, Cigna's advertisements are not "truthful" and are "misleading in fact or in implication" in violation of 10 CCR § 2536.1(b).

b. By misrepresenting the providers that would be in-network under Plaintiff's and Class Members' plans, Cigna is failing to "provide, in easily understood language and in a uniform, clearly organized manner" information about Plaintiff's and Class Members' plans, including the "principal benefits and coverage of the disability insurance policy" and the "exceptions, reductions, and limitations that apply to such policy" in violation of Insurance Code sections 10603(a)(1) and 10604(a).

c. By misrepresenting the providers that would be in-network under Plaintiff's and Class Members' plans, Cigna's policies and contracts with Plaintiff and Class Members are not "fair and reasonable" and "inconsistent with standards of good health care and clinically appropriate care" in violation of Insurance Code section 10133.5.

d. By misrepresenting the providers that would be in-network under Plaintiff's and Class Members' plans, Cigna has failed to "ensure that … [n]etwork providers are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services" in violation of 10 CCR § 2240.1(b)(1).

e. 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 during their course of treatment, Cigna is failing to provide covered services in violation of Insurance Code section 10133.56.

77. Plaintiff and Class Members have suffered injury in fact and lost money and/or property as a result of Cigna's and Does 1 through 100's unlawful business acts and practices by, inter alia, receiving lesser coverage under their health service plan contracts, paying

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unexpected out-of-pocket costs and premiums that are not commensurate with the coverage provided, 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.

78. As a result of Cigna's and Does 1 through 100's violations of the Business and Professions Code section 17200, Plaintiff seeks an order of this Court enjoining Cigna's continued violations. Plaintiff also seeks an order for restitution of all monies paid for Cigna health service plans in an amount reflecting the difference in the value of the health service plans with the networks of providers that Cigna claimed were in-network and the value of the health plans with the narrow network.

SECOND CAUSE OF ACTION

Violations of Business & Professions Code § 17200, et seq. – Unfair Business Acts and Practices

79. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

80. Cigna's conduct, and the conduct of Does 1 through 100, as described above, constitutes unfair business acts and practices under Business and Professions Code section 17200, et seq.

81. Plaintiff and other members of the Class suffered a substantial injury in fact resulting in the loss of money or property by virtue of Cigna's and Does 1 through 100's conduct.

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

83. Plaintiff and Class Members could not have reasonably avoided the injury each of them suffered.

84. The gravity of the consequences of Cigna's and Does 1 through 100's conduct as described above outweighs any justification, motive or reason therefore and is immoral,

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unethical, oppressive, unscrupulous, and offends established public policy delineated in California law, Insurance Code, and regulatory provisions as well as their underlying purposes.

85. Plaintiff and Class Members have suffered injury in fact and lost money and/or property as a result of Cigna's and Does 1 through 100's unfair business acts and practices by, inter alia, receiving lesser coverage under their health service plan contracts, paying unexpected out-of-pocket costs and premiums that are not commiserate with the coverage provided, 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.

86. As a result of Cigna's and Does 1 through 100's violations of the Business and Professions Code section 17200, Plaintiff seeks an order of this Court enjoining Cigna's continued violations. Plaintiff also seeks an order for restitution of all monies paid for Cigna health service plans in an amount reflecting the difference in the value of the health service plans with the networks of providers that Cigna claimed were in-network and the value of the health plans with the narrow network.

THIRD CAUSE OF ACTION

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

Fraudulent Business Acts and Practices

87. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

88. Cigna's conduct, and the conduct of Does 1 through 100, as described above, constitutes fraudulent business practices under Business and Professions Code section 17200, et seq.

89. Defendants' misleading and fraudulent representations, advertising, marketing, and communications are likely to deceive reasonable California consumers. Plaintiff and Class Members were unquestionably deceived regarding the provider networks, and Cigna's

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other misrepresentations and omissions as more fully described herein.

90. Cigna's misrepresentations and omissions were material and were a substantial factor in Plaintiff's and Class Members decisions to enroll in and renew their health plan contracts and continue to pay monthly premiums. Such acts are fraudulent business acts and practices.

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

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

93. As a result of Cigna's and Does 1 through 100's violations of the Business and Professions Code section 17200, Plaintiff seeks an order of this Court enjoining Cigna's continued violations. Plaintiff also seeks an order for restitution of all monies paid for Cigna health service plans in an amount reflecting the difference in the value of the health service plans with the networks of providers that Cigna claimed were in-network and the value of the health plans with the narrow network.

FOURTH CAUSE OF ACTION

Violations of the California False Advertising Law,

Business & Professions Code § 17500, et seq.

94. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

95. 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, and making other misrepresentations and omissions as more fully described herein.

96. These representations have deceived and are likely to deceive Plaintiff and Class Members in connection with their decisions to purchase their individual health service contracts and to continue to pay monthly premium charges. Defendants' representations also

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have deceived and are likely to deceive Plaintiff and Class Members with respect to the expected costs they would be spending out-of-pocket under their individual health plan contracts. Defendants' representations were material and were a substantial and material factor in Plaintiff's and Class Members' decisions to purchase their health service plans and to continue to pay monthly premium charges. Had Plaintiff and Class Members known the actual facts, they would not have purchased the health plans, continued to pay monthly premium charges, or 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.

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

98. 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.

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

100. As a result of Cigna's and Does 1 through 100's violations of the Business and Professions Code section 17500, Plaintiff seeks an order of this Court enjoining Cigna's continued violations. Plaintiff also seeks an order for restitution of all monies paid for Cigna health service plans in an amount reflecting the difference in the value of the health plans with the networks of providers that Cigna claimed were in-network and the value of the health plans with the narrow network.

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FIFTH CAUSE OF ACTION

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

101. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

102. 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).)

103. Here, in connection with Cigna 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

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rights, remedies, or obligations which they do not have.

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

104. Such acts and practices were designed or intended by Cigna to convince Class Members to initially purchase and pay monthly premium charges. 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 monthly premium payments of the individual PPO health plan contracts made and entered into by Cigna, Plaintiff and Class Members, as well as Cigna's performance of its obligations under such agreements. In making decisions whether to initially purchase Cigna health plans and pay monthly premium charges, Plaintiff and Class Members reasonably acted in positive response to Cigna's misrepresentations as set forth in detail herein, or would have considered the omitted facts detailed herein material to their decisions to do so.

105. 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." Cigna's ongoing "work and labor" to establish, maintain, and improve provider networks of hospital and doctors is the core of the PPO health service plans at issue here. Cigna provides extensive services that do not exist for consumers enrolled in pure indemnity coverage like life insurance. For example:

- Cigna advertises its PPO coverage by promoting the network services it provides and the "work and labor" Cigna expends in order to guarantee quality and provide

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consumer choice. Cigna promises: "The LocalPlus Network can give you easy access to a select group of local, quality doctors and hospitals where you live and work."[2] Cigna'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 PPO health service plans, consumers must visit one of the preferred providers in Cigna's network. PPO consumers benefit from Cigna'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.

- Cigna expends a tremendous amount of "work and labor" to build and managed its provider networks, which often requires Cigna 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, Cigna expends significant "work and labor" to construct provider networks by sponsoring initiatives aimed at providing integrated and cost efficient health care.

- Of the enormous resources that Cigna spends on administration of health service plans, a substantial portion is dedicated to its work and labor pertaining to its preferred provider networks.

106. The services at issue here are not "ancillary services." Instead, the services discussed above are the core of Plaintiff's PPO health service plan.

107. Cigna violated the CLRA by committing unfair and deceptive acts that directly undermined Plaintiff's and Class Members' ability to access the provider network they were promised. Cigna's unfair and deceptive acts increased Plaintiff's and Class Members' costs and unilaterally reduced treatments and services available from those provider networks.

108. Plaintiff and Class Members have suffered harm as a result of these violations. Plaintiff and Class Members purchased individual health plan contracts, and paid monthly premiums, reasonably relying on Cigna's material misrepresentations, inter alia, that certain providers would be in-network. Plaintiff and Class Members have also suffered transactional costs by expending time and resources in the form of correspondence and telephone conversations with Cigna's customer service representatives in an attempt to avoid the

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[2] Cigna, LocalPlus Network Flyer, http://www.cigna.com/assets/docs/individual-and-families/medical-plans/common/866355-localplus-d2c-az-fl-tn-tx-co-ca.pdf (last visited September 15, 2014).

consequences of Cigna's unfair methods of competition and unfair or deceptive acts. Plaintiff and Class Members have also suffered opportunity costs by foregoing the opportunity to switch to other coverage offered by other companies during the Open Enrollment Period.

109. 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.

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

111. 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.

112. 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.

113. Plaintiff and the Class are entitled to an injunction, pursuant to Civil Code section 1780, prohibiting Cigna from continuing to engage in the above-described violations of the CLRA.

114. Cigna's conduct as described herein was intended by Cigna to cause injury to members of the Class and/or was despicable conduct carried on by Cigna 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 Cigna with the intention to deprive Class Members of property or legal rights, or to otherwise cause injury, such as to

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constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiff and members of the Class to exemplary damages in an amount appropriate to punish or set an example of Cigna.

SIXTH CAUSE OF ACTION

Breach of Contract

115. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

116. Cigna and Does 1 through 100 owe duties and obligations to Plaintiff and members of the Class under the health service plan contracts at issue.

117. By misrepresenting provider networks and denying coverage for medical services on the basis that services were provided by an out-of-network provider that Cigna represented as in-network, Cigna and Does 1 through 100 have uniformly breached the terms and provisions of the individual health service plan contracts entered into with Plaintiff and members of the Class.

118. As a direct and proximate result of Cigna's and Does 1 through 100's conduct and breach of contractual obligations, Plaintiff and members of the Class suffered damages under the individual plan contracts in an amount to be determined according to proof at of trial.

SEVENTH CAUSE OF ACTION

Breach of the Implied Covenant of Good Faith and Fair Dealing

119. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

120. Cigna and Does 1 through 100 have breached their duty of good faith and fair dealing owed to Plaintiff and members of the Class in the following respects:

a. Unreasonably misrepresenting provider networks covered under the individual health service plan contracts; and

b. Unreasonably denying coverage for medical services on the basis that

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services were provided by an out-of-network provider that Cigna represented as in-network.

121. Plaintiff is informed and believes and thereon alleges that Cigna and Does 1 through 100 have breached their duty of good faith and fair dealing owed to Plaintiff and members of the Class by other acts or omissions of which Plaintiff is presently unaware and which will be shown according to proof at trial.

122. As a proximate result of the aforementioned unreasonable and bad faith conduct of Defendants, Plaintiff and members of the Class have suffered, and will continue to suffer in the future, damages under the health service plan contracts, plus interest, and other economic and consequential damages, in an amount to be proven at trial.

123. As a further proximate result of the unreasonable and bad faith conduct of Defendants, Plaintiff and members of the Class were compelled to retain legal counsel and to institute litigation to obtain the benefits due under the contracts. Therefore, Defendants are liable for those attorneys' fees, witness fees and litigation costs reasonably incurred in order to obtain their benefits under the health service plan contracts.

124. Defendants' conduct described herein was intended by the Defendants to cause injury to members of the Class and/or was despicable conduct carried on by the Defendants 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 the Defendants with the intention to deprive members of the Class property, legal rights or to otherwise cause injury, such as to constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiff and members of the Class to punitive damages in an amount appropriate to punish or set an example of Defendants.

125. Defendants' conduct described herein was undertaken by Cigna's and Does 1 through 100's officers or managing agents who were responsible for claims supervision and operations decisions. The previously described conduct of said managing agents and individuals was therefore undertaken on behalf of Cigna. Cigna further had advance

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knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents whose precise identities are unknown to Plaintiff at this time and are therefore identified and designated herein as Does 1 through 100.

EIGHTH CAUSE OF ACTION

Declaratory Relief

126. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

127. 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."

128. An actual controversy has arisen between Plaintiff and the Class Members she represents, on the one hand, and Cigna and Does 1 through 100 on the other hand, as to their respective rights and obligations under the individual health service plan contracts between them. Specifically, Plaintiff and Class Members contend that Cigna's and Does 1 through 100's misrepresentation of provider networks and other misrepresentations and omissions as more fully described herein are prohibited by California law. Defendants contend that their conduct was proper.

129. Plaintiff seeks a declaration as to the respective rights and obligations of the parties.

PRAYER FOR RELIEF

Plaintiff, on her own behalf and on behalf of the Class, prays for relief as follows, as applicable to the causes of action set forth above:

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1. An Order certifying the proposed Class pursuant to Code of Civil Procedure section 382 and Civil Code section 1780 et seq. and appointing Plaintiff to represent the proposed Class and designating her counsel as Class Counsel;
2. An Order enjoining Cigna from continuing to engage in the conduct described herein;
3. An Order awarding Plaintiff and the Class restitution and such other relief as the Court deems proper;
4. An Order awarding Plaintiff and the Class damages for failure to provide coverage under the contracts, plus interest, including prejudgment interest, and other economic and consequential damages, in a sum to be determined at the time of trial;
5. An Order awarding Plaintiff and the Class punitive and exemplary damages in an amount appropriate to punish or set an example of Defendants;
6. An Order declaring the rights and obligations of Plaintiff and Class Members, on the one hand, and Cigna, on the other, with regard to the business practices alleged;
7. An Order awarding Plaintiff's attorneys' fees, costs and expenses as authorized by applicable law; and
8. For such other and further relief as this Court may deem just and proper.

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JURY DEMAND

Plaintiff demands a trial by jury on all issues so triable.

DATED: September 23, 2014

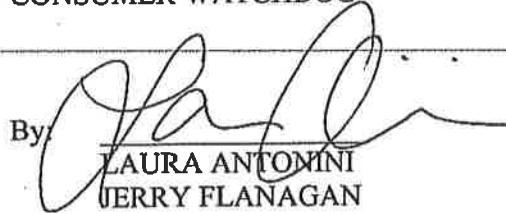
Respectfully Submitted,

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP

By: ____________________

MICHAEL J. BIDART
TRAVIS M. CORBY

CONSUMER WATCHDOG



By: ____________________

LAURA ANTONINI
JERRY FLANAGAN

Attorneys for Plaintiff

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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 Plaintiff 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 described 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 Defendants Cigna Health and Life Insurance Company and Cigna Healthcare of California, Inc. are 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 24th day of September 2014, at Santa Monica, California.

LAURA ANTONINI

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