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IN THE SUPERIOR COURT OF CALIFORNIA

COUNTY OF LOS ANGELES

JANET KASSOUF, ALISON HEATH, and DAVID JACOBSON, individually, and on behalf of others similarly situated **Plaintiffs,** **v.** **BLUE CROSS OF CALIFORNIA, d/b/a ANTHEM BLUE CROSS; DOES 1-100, inclusive** **Defendants.**	**Case No. BC473408** **FIRST AMENDED CLASS ACTION COMPLAINT AND AFFIDAVIT** **Breach of Contract** **Breach of the Implied Covenant of Good Faith and Fair Dealing** **Declaration of Rights, Code Civ. Proc. § 1060** **Violations of the Consumers Legal Remedies Act, Civil Code § 1750 et seq.** **Violations of Unfair Competition Law, Bus. & Prof. Code § 17200 et seq.**

Plaintiffs, by their attorneys, bring this action on behalf of themselves and all others similarly situated against Blue Cross of California dba Anthem Blue Cross (hereafter "Blue Cross"). Plaintiffs allege the following on information and belief, except as to those allegations that pertain to the named Plaintiffs, which are alleged on personal knowledge:

NATURE OF THE ACTION

1. Plaintiffs bring this action to challenge an insidious and devastating form of bait and switch. Blue Cross represents and markets its health service plans as having an "annual deductible" and other "annual" and "yearly" benefits and out of pocket costs. However, in 2011, Blue Cross unilaterally:

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- Increased "annual deductibles" and other "annual" and "yearly" out of pocket costs, thereby reducing the benefits available under the health plan contracts, in the *middle* of the year. As a result, Plaintiffs and Class members must pay more than promised for covered medical treatments.[1]

- Adopted new contract provisions allowing Blue Cross to change "any term or benefit" of its heath service plans each month on just sixty days notice.

- Converted individual health service plan contracts from annual to month-to-month in duration. Thus, the health service plans now terminate at the end of each month and "renew" upon payment of the next month's premium. As a result, consumers are more likely to be terminated due to payments delayed by mail or processing errors by Blue Cross.

2. Under the terms of the health service plans at issue, regulated by the Department of Managed Health Care ("DMHC"), the deductible is the amount of medical expenses that the consumer must pay out of pocket before Blue Cross will pay for covered services (with some exceptions). Generally, the higher the deductible, the lower the premium and vice versa. Other than the amount of the monthly premium, the annual deductible is the central term and an essential benefit of the health service plan contract ("Evidence of Coverage" or "EOC"), and until after Plaintiffs filed this lawsuit, the amount of the annual deductible was incorporated in the name of the plan. For example, the "PPO Share 2500" plan was so named because of its $2,500 "annual deductible."

3. When Plaintiffs and Class members originally purchased health service plan contracts with an annual deductible of $2,500, for example, and renewed those contracts each month, Plaintiffs and Class members expected they would have to pay the first $2,500 in medical treatments during the calendar year. Once the "annual" deductible was met, Blue Cross would cover the remaining costs of treatments according to the terms of the plan contract. Blue Cross's unilateral mid-year changes to annual deductibles, however, have resulted in a moving target eviscerating any certainty or piece of mind as to how much consumers will have to spend before Blue Cross pays claims for medical treatments.

4. Blue Cross's unilateral changes undermine a key purpose for which Class

[1] See the chart—"Individual/Family Benefit Changes Effective May 1, 2011"—that Blue Cross sent to Class members announcing the changes, which is part of Exhibit "E" of this complaint and incorporated herein by reference.

members purchased and renewed their Blue Cross health service plans. The principle characteristic of Blue Cross's "preferred provider organization" ("PPO") health service plans at issue is an extensive network of approved health care providers, including doctors and hospitals, with whom Blue Cross contracts, after certifying their quality, to provide a range of covered medical treatments at a negotiated price to consumers. The services at issue here are Blue Cross's extensive and ongoing "work and labor"[2] on behalf of Plaintiffs and Class members to review and approve the quality of doctors and hospitals and establish, maintain, and improve "preferred provider" networks. These are not ancillary services; this work and labor is in fact the *central purpose* of Preferred Provider Organization health service plan contracts. But for these preferred provider networks, there would be no "PPO."

5. As explained below, Blue Cross advertises its PPO coverage by promoting these network services and the "work and labor" Blue Cross expends in order to guarantee quality and provide consumer choice. Blue Cross's website promises: "Network – Quality. We work with our network doctors and hospitals, so you can get high-quality care at a low cost" and, "Network – Choice. Our large networks mean you will likely find doctors that you know." Simply, Plaintiffs and Class members purchased and renewed their Blue Cross PPO contracts for the key purpose of *gaining and retaining access* to Blue Cross's network of "preferred providers." (A common refrain is, "I want to keep my doctor.") It is this network of "preferred providers" that differentiates health service plans from pure "indemnity" insurance.

6. Blue Cross's unilateral increases to annual deductibles and other out of pocket costs, and adoption of unconscionable contract provisions, have erected a financial barrier between Plaintiffs and the very preferred provider network they are seeking to access. Therefore, the benefits that Blue Cross unilaterally degraded are inextricably intertwined with the services at issue. By (i) increasing the amount that Plaintiffs must spend before Blue Cross pays claims for covered medical treatments, (ii) increasing Plaintiffs' co-pay requirements and share of costs, and (iii) unilaterally altering other benefits each month, Blue Cross is directly undermining Plaintiffs'

[2] The Consumers Legal Regal Remedies Act 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." (Civ. Code § 1761(b).)

ability to access the "services" at issue: Blue Cross's preferred provider network which is organized for the purpose of providing specified medical treatments and services enumerated in the EOCs.

7. The sudden and unexpected roadblocks to the very services sold to Class members highlight Blue Cross's misrepresentations and other illegal and unfair acts. As deductibles and other out of pocket costs increase, the ability of consumers to avail themselves of the promised service diminishes. Higher deductible and annual co-payment amounts lead individuals to avoid necessary medical care, impose a substantial financial burden, and undermine one of the primary reasons that people enroll in health service plans in the first place: protection from financial ruin if they become seriously ill. Moreover, higher deductible and annual co-payment amounts place a financial burden on the poorest and sickest members of society. As a result, chronic conditions worsen and diagnoses of serious medical conditions are delayed. As one consumer put it, a higher deductible "meant wrenching days of weighing a child's spiking fever or sports injury against the out-of-pocket cost of seeing a doctor—or, even worse, going to an emergency room." Higher than promised deductibles and annual co-pay requirements make a consumer think twice before visiting a doctor.

8. Blue Cross claimed that the mid-year changes to "annual" and "yearly" out of pocket costs were necessary to protect consumers from premium increases, yet Blue Cross:

a. Simultaneously increased premiums by 20% or more.

b. Had five times the required reserves (tangible net equity ["TNE"])—$1.2 billion in *excess* of state-mandated TNE—as of June 30, 2011 while the company paid $500 million in dividends to shareholders in 2011. In 2012, Blue Cross paid another $450 million in dividends to shareholders.

c. Implemented the mid-year changes in an arbitrary and inconsistent way. Blue Cross postponed similar mid-year changes to its nearly identical health service plans regulated by the California Department of Insurance.

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9. Through its conduct of unilaterally decreasing benefits by escalating annual deductibles and other out of pocket costs, and unilaterally altering EOCs to allow Blue Cross to change "any term or benefit" each month, Blue Cross has breached the individual health service plan contracts entered into with Plaintiffs and Class members and breached the implied covenant of good faith and fair dealing.

10. Blue Cross's misrepresentations about the "annual" duration, benefits, and costs of its health service plans also violate Health and Safety Code section 1360, which bars Blue Cross from: (i) using any advertising or solicitation which is "untrue or misleading", (ii) using any EOC which is deceptive, or (iii) making any statement or representation about coverage or its costs that is untrue, misleading, or deceptive.

11. The unilateral changes to individual plan contracts, and the new contract provisions allowing Blue Cross to change "any term or benefit" each month, also violate regulations barring Blue Cross from imposing restrictions or limitations which render benefits "illusory."

12. Blue Cross's bait and switch tactics of representing and advertising that its health service plans have "annual" and "yearly" benefits and out of pocket costs of one amount and then unilaterally changing those benefits in the middle of the year violates the Consumers Legal Remedies Act ("CLRA"), California Civil Code section 1750, et. seq, as does Blue Cross's adoption of unconscionable contract provisions allowing Blue Cross to change "any term or benefit" each month.

13. Blue Cross's unilateral adoption and enforcement of unconscionable EOC provisions also violates Civil Code section 1670.5.

14. Finally, Blue Cross's and Does 1 through 100's unlawful, unfair and fraudulent conduct violates California Business & Professions Code section 17200, et seq.

15. Plaintiffs bring this action on behalf of themselves and on behalf of a class of current California residents who are currently enrolled in a Blue Cross individual plan contract or who were enrolled in a Blue Cross individual plan contract during the four years preceding the filing of the original Complaint in this action up to and including the date this action is certified

as a class (the "Class").

16. Plaintiffs further seek an order of this Court enjoining Blue Cross's and Does 1 through 100's continued violations. Plaintiffs also seek an order for disgorgement and restitution of Defendants' revenues, profits and other benefits from improperly decreased benefits.

THE PARTIES

17. Plaintiff Alison Heath is a resident of San Francisco, California. Until approximately July 2012, Ms. Heath was enrolled in a Blue Cross PPO Share $2,500 individual health service plan contract subject to Defendants' May 1, 2011 increase of the plan's annual deductible and other mid-year changes, as well as the August 1, 2011 unilateral change reducing the health service plan duration to month-to-month and allowing Blue Cross to change "any term or benefit" of the health service plan contract each month on just sixty days notice. Ms. Heath's PPO Share $2,500 plan was also subject to the changes announced in the October 2011 Letter described below. Ms. Heath is currently enrolled in a Premier Plus 5000 plan offered by Blue Cross. A key reason for Ms. Heath's decision to switch to the Premier Plus 5000 plan in or around July 2012 was the fact that Blue Cross had so severely degraded the benefits available under her PPO Share $2,500 plan. Unfortunately, Ms. Heath's Premier Plus 5000 health plan is also subject to the same contract provision allowing Blue Cross to unilaterally change any benefit or term each month. Attached as Exhibit "A" is a true and correct copy of Plaintiff Alison Heath's Evidence of Coverage for her PPO Share $2,500 plan, which is incorporated herein by reference.

18. Plaintiff Janet Kassouf is a resident of Hayward, California. Ms. Kassouf is enrolled in a Blue Cross PPO Share $1,500 individual plan contract subject to Defendants' May 1, 2011 increase of the plan's annual deductible and other mid-year changes, as well as the August 1, 2011 unilateral change reducing the health service plan duration to month-to-month and allowing Blue Cross to change "any term or benefit" of the health service plan contract each month on just sixty days notice. Ms. Kassouf's PPO Share $1,500 plan was also subject to the changes announced in the October 2011 Letter described below. Attached as Exhibit "B" is a true and correct copy of Plaintiff Janet Kassouf's Evidence of Coverage, which is incorporated herein by reference.

19. Plaintiff David Jacobson is a resident of Santa Monica, California. Mr. Jacobson is enrolled in a Blue Cross PPO Share $500 individual plan contract subject to Defendants' May 1, 2011 increase of the health service plan's annual deductible and other mid-year changes, as well as the August 1, 2011 unilateral change reducing the health service plan duration to month-to-month and allowing Blue Cross to change "any term or benefit" of the health service plan contract each month on just sixty days notice. Mr. Jacobson's PPO Share $1,500 plan was also subject to the changes announced in the October 2011 Letter described below. Attached as Exhibit "C" is a true and correct copy of Plaintiff David Jacobson's Evidence of Coverage, which is incorporated herein by reference.

20. Defendant Blue Cross is a corporation duly organized and existing under the laws of the State 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 plans throughout this state.

21. The true names or capacities, whether individual, corporate, associate, or otherwise, of Does 1 through 100, inclusive, are unknown to the representative Plaintiffs, who therefore sue said Defendants by such fictitious names. Representative Plaintiffs are informed and believe and thereon allege that each of the Defendants sued herein as a Doe is legally responsible in some manner for the events and happenings referred to herein, and will ask leave of this court to amend his Complaint to insert their true names and capacities in place and instead of the fictional names when the same becomes known to the representative Plaintiffs.

22. At all relevant times, Defendants, and each of them, were the agents and employees of each of the remaining Defendants, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved said agency and employment, and each defendant has ratified and approved the acts of its agent.

JURISDICTION AND VENUE

23. 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 section Civil Code 1750

et. seq.

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

25. 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.

26. 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.

27. Venue is proper in this Court because Plaintiff Jacobson and many Class Members did business with Blue Cross in this County, Blue Cross engaged in business in this County, and because Blue Cross received substantial profits from policyholders who reside in this County.

STATUTORY AND REGULATORY SCHEME

28. The individual health service plan contracts at issue in this class action are subject to the requirements of Health and Safety Code sections 1340 through 1399.99 (the "Knox-Keene Act").

29. 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).)

30. Health & 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]*.”

31. To further the goals of ensuring that consumers are educated and informed about coverage benefits and enabling rational consumer choice in the marketplace, the Knox-Keene Act requires the Director of the Department of Managed Health Care to compel health service plans to explain plan contract benefits and limitations in “concise and specific terms” (Health & Saf. Code § 1363(a)(1)-(2)) and to include a “coverage matrix” at the beginning of each Evidence of Coverage which discloses individual health service plan contract coverage benefits. (Health & Saf. Code § 1363(b)(1).) Health service plans are specifically required by statute to list the plan “deductible” first in the coverage matrix. (Health & Saf. Code § 1363(b)(1)(A).)

32. The Knox-Keene Act also bars health 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 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).)

c. "An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of plans, and evidence of coverage therefor to expect benefits, service charges, or other advantages which the evidence of coverage does not provide or which the plan issuing such coverage or evidence of coverage does not regularly make available to enrollees or subscribers covered under such evidence of coverage." (Id. at (a)(3).)

33. Under section 1300.67.4, subdivision (a)(3)(A) of Title 28 of the California Code of Regulations ("28 CCR"), applicable to the Blue Cross individual plan contracts subject to this class action, "[a] benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or copayment which renders the benefit illusory."

FACTUAL ALLEGATIONS

34. Health service plans are not pure "indemnity" insurance like life insurance policies. Blue Cross does not merely pay doctors and hospitals to provide medical treatments to consumers. Blue Cross expends significant and ongoing "work and labor" on behalf of its customers to ***identify and contract with high quality hospitals*** and doctors who agree to provide covered benefits at lower rates. To avail themselves of the lower rates, Blue Cross health service plan members must agree to utilize those preferred providers. It is precisely these networks of approved high-quality "preferred providers"—and the "work and labor" required to identify providers and build and maintain the networks—that distinguishes the health service plans at issue here from the life insurance policies. The service Blue Cross provides its customers cannot be monetized, treated as an asset, assigned or borrowed against, such as one could with a life insurance policy.

35. Blue Cross and Does 1 through 100 often represent, market, and advertise individual health service plan contracts as having "annual" or "calendar year" deductibles and other benefits. Attached as Exhibit "D" is a true and correct copy of a Blue Cross marketing

brochure, incorporated herein by reference, listing the "calendar year" deductibles of various individual health service plans, including the PPO Share plans in which Plaintiffs Alison Heath, Janet Kassouf, and David Jacobson are enrolled.

36. Plaintiffs Janet Kassouf and David Jacobson are currently enrolled in Blue Cross PPO Share $1,500 and $500 individual health service plan contracts, respectively. Plaintiffs Kassouf and Jacobson have been enrolled in their respective plans for more than ten years. Plaintiff Alison Heath was previously enrolled in PPO Share $2,500 health service plan. (Kassouf's, Heath's, and Jacobson's PPO Share health plans are referred to herein as "the Plans"). The dollar value in each health service plan name indicates the amount of the original annual deductible.

37. The Plans' EOC states that "[d]uring each Year, each Member is responsible for all expense incurred for Covered Services up to the Deductible amount." Under the terms of the Plans' EOCs, for example, Plaintiffs Kassouf and Jacobson are responsible for an annual deductible of $1,500 and $500 respectively calculated from January 1, 2011 to December 31, 2012. (See e.g., Exhibit A, p. 55 ["Year is a twelve-month period starting each January 1 at 12:01 a.m. Pacific Standard Time.].) After the Member has met his or her annual deductible, Blue Cross is supposed to pay the cost of all remaining covered medical expenses except for Plaintiffs' share of copay and coinsurance costs, which are required in addition to deductible payments up to the Yearly Maximum Copayment/Coinsurance Limit, for the remaining calendar year incurred by Plaintiffs with Blue Cross "participating providers."

38. At the top of the first page of the Plans' EOC, the very first "benefit" listed in the coverage matrix is the "annual deductible." There are more than a half-dozen other references to "yearly" benefits in the coverage matrix. In addition to ten references in the EOC to the "annual deductible" or "yearly deductible," the words "annual," "yearly," "calendar-year" and "per year," modifying terms other than "deductible," are used sixty-eight times throughout the EOC, nineteen of which are in the coverage matrix.

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February 2011 Letter

39. In or around February 2011, just two months into the deductible year, Blue Cross and Does 1 through 100 sent Plaintiffs a letter ("the February 2011 Letter") advising Plaintiffs that Defendants planned to reduce the benefits under the Plans in several ways effective May 1, 2011, namely by increasing the annual deductible from:

- $2,500 to $2,950 for Plaintiff Heath.
- $1,500 to $1,750 for Plaintiff Kassouf.
- $500 to $550 for Plaintiff Jacobson.

40. In addition, the February 2011 Letter informed Plaintiffs that Defendants would be making other changes to the Plans, including: increasing the Plan premiums by more than 20% while increasing the Yearly Maximum Copayment/Coinsurance Limit (the total amount Plaintiffs must pay out of pocket each year including annual deductible and copayment/coinsurance requirements) from:

- $7,500 to $8,800 for Plaintiff Heath.
- $6,000 to $7,050 for Plaintiff Kassouf.
- $5,000 to $5,850 for Plaintiff Jacobson.

Additionally, the "annual" prescription drug deductible would increase from:

- $500 to $575 for Plaintiff Heath.
- $250 to $275 for Plaintiffs Kassouf and Jacobson.

Attached as Exhibit "E" is a true and correct copy of the February 2011 Letter, which is incorporated herein by reference. Included in Exhibit "E" is a chart titled "Individual/Family Benefit Changes Effective May 1, 2011" that Blue Cross sent to Class members along with the February 2011 Letter. The chart summarizes the benefit changes to the health service plans at issue.

41. Blue Cross and Does 1 through 100 announced similar unilateral mid-year changes to the annual out of pocket costs imposed on Class members enrolled in other Blue Cross individual plan contracts. According to the February 2011 Letter, annual deductibles for the:

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- PPO Share 1000 plan would increase from $1000 to $1,150.
- PPO Share 3500 plan would increase from $3,500 to $4,100.
- PPO Share 5000 plan would increase from $5000 to $5,900.
- PPO Share 7500 plan would increase from $7,500 to $8,850.

In addition, the February 2011 Letter announced increased premiums, increased annual copayment/coinsurance maximums, and increased annual prescription drug deductibles.

Arbitrary Implementation

42. In contrast with the conduct we have discussed, Blue Cross's affiliate regulated by a different California agency took another approach. On March 21, 2011, the California Department of Insurance ("CDI"), which regulates Blue Cross Life and Heath Insurance Company, announced that the company would delay deductible and copay increases until January 1, 2012 and premium increases until July 1, 2011.[3] Though the announcement did not distinguish between Blue Cross's CDI and DMHC-regulated coverage, it became apparent soon after the announcement that though Blue Cross would delay mid-year changes to its annual deductibles for its CDI-regulated health service plans it would not delay increases to annual deductibles and other benefit changes for its DMHC-regulated plans.[4] On May 1, 2011 Blue Cross implemented the mid-year policy changes on its DMHC-regulated plans.

43. After seeking medical treatment under the terms of his Blue Cross individual plan contract, Plaintiff David Jacobson reached his $500 deductible in or about March of 2011. Defendants honored Plaintiff Jacobson's $500 deductible for medical treatments received in April 2011, thus paying for the treatments without requiring an additional deductible payment from Plaintiff Jacobson. However, following the May 1, 2011 increase of Plaintiff Jacobson's annual deductible to $550, Defendants required Plaintiff Jacobson to pay an additional $50 deductible for medical care sought in July 2011.

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[3] Helfand, *Anthem Blue Cross reduces rate increases*, L.A. Times (Mar. 21, 2011), available at http://www.latimes.com/business/la-fi-anthem-rates-20110322,0,7112310.story.

[4] Helfand, *Cuts to Anthem's rate hikes are not for everyone*, L.A. Times (Apr. 8, 2011), available at http://articles.latimes.com/2011/apr/08/business/la-fi-anthem-rates-20110408.

August 2011 Endorsement

44. Around the same time that it implemented the mid-year changes to annual deductibles and other annual benefits and out of pocket costs, Blue Cross mailed to consumers in or about May 2011 an “Endorsement to the Individual PPO Share” health service plan contracts effective August 1, 2011 (“August 2011 Endorsement”). The effect of the August 2011 Endorsement, which inserted new terms into individual health service plan contracts, is to allow Blue Cross to change “any term or benefit,” including “annual” deductibles, and to otherwise “modify or . . . change the terms and conditions” of the plan “including, without limitation, subscription charges, covered benefits, Deductibles, copayments or coinsurance” each month on 60 days notice. (“For example, Anthem can change the Deductible for the Agreement on sixty (60) days notice during the year in which the Deductible is accruing.”) Under the new contract terms unilaterally adopted by Blue Cross in August 2011, Plaintiffs’ and Class members’ health service plans terminate at the end of each month and “renew” upon payment of the next month’s premium. The August 2011 Endorsement provides that Blue Cross may make changes to the health services plan at each monthly “renewal.” Attached as Exhibit “F” is a true and correct copy of the August 2011 Endorsement, which is incorporated herein by reference.

45. Blue Cross immediately exercised the unconscionable contract provisions of the August 2011 Endorsement by unilaterally (i) converting health service plan contracts to month-to-month, (ii) adopting new billing procedures requiring all Class members to, as of August 1, 2011, pay their premium charges each month whereas in the past consumers could pay quarterly or bi-annually, and (iii) revoking agreements it had entered into with Class members allowing them to pay their premium payments through automatic credit card transfers. Class members wishing to pay with a credit card after August 1, 2011 must now call Blue Cross each month and pay over the phone causing class members to suffer damages in the form of lost time resulting from long hold times. These changes were described in a letter accompanying the August 2011 Endorsement sent to all Blue Cross enrollees, a true and correct copy of which is attached as Exhibit “G” and incorporated herein by reference.

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October 2011 Letter

46. In or around October 2011, Blue Cross sent a letter to Plaintiffs describing additional changes to the Plans, including changes to the Plans' names ("the October 2011 Letter"). According to the October 2011 Letter, as of January 1, 2012 "your plan name [will] no longer include the deductible amount." The letter included an endorsement to the Plans that added a paragraph above the Coverage Matrix on the first page of the Evidence of Coverage. According to the October 2011 Letter, this paragraph was intended "to clarify that the benefits listed [in the Coverage Matrix] can change and be effective following 60 days written notice to you." The October 2011 Letter also announced that as of January 1, 2012 travel expenses related to organ transplants would be capped at $10,000. Attached as Exhibit "H" is a true and correct copy of the October 2011 Letter, which is incorporated herein by reference.

47. Plaintiffs and Class members never requested or agreed to any of the unilateral changes discussed herein.

BLUE CROSS'S ILLEGAL ACTS

48. As discussed in more detail herein, through its conduct of unilaterally degrading "annual" and "yearly" benefits, unilaterally altering EOCs to allow Blue Cross to change "any term or benefit" each month on just sixty days notice, unilaterally converting health service plans to month-to-month, and unilaterally exercising such unconscionable terms, Blue Cross:

- Breached the individual health service plan contracts entered into with Plaintiffs and Class members and breached its duty of good faith and fair dealing.
- 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, or any EOC that is deceptive. Blue Cross's misrepresentations and untrue statements about "annual" costs and the "annual" duration of plan contracts also violate Health and Safety Code section 1360.
- Violated provisions of the California Code of Regulations barring health service plans from imposing restrictions or limitations that render contract benefits "illusory."

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49. Defendant engaged in various unfair and deceptive acts in violation of the CLRA by:

- Unilaterally adopting unconscionable provisions in its contracts allowing Blue Cross to change "any term or benefit" of Plaintiffs' health service plans, including "annual deductibles" and other "yearly" benefits, each month, and reducing the plan contract duration to month-to-month in violation of Civil Code section 1770, subdivision (a)(19).

- Representing that health service plans provide "annual" contracts with "annual" and "yearly" benefits which they do not have in violation of Civil Code section 1770, subdivision (a)(5).

- Advertising health services plans as being "annual" in nature and providing "annual" and "yearly" benefits 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 an "annual deductible" and other "yearly" benefits and out of pocket costs of one amount and then unilaterally changing those benefits during the annual period the costs are accruing in violation of Civil Code section 1770, subdivision (14).

CLASS ALLEGATIONS

50. This action is brought on behalf of the Plaintiffs individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382. Plaintiffs seek to represent the following class:

> All current California residents who are currently enrolled in, or who were enrolled in, a Blue Cross individual plan contract whose annual deductible and other "annual" and "yearly" benefits were unilaterally degraded mid-year, and/or whose individual plan contracts contain or contained provisions limiting the plan contract to month-to-month in duration and allowing Blue Cross to change any term or benefit each month.

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

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

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

54. 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.

55. 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.

56. 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 the Plaintiffs and absent Class members.

57. 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.

58. 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.

59. 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.

60. Plaintiffs anticipate no unusual management problems with the pursuit of this Complaint as a class action.

FIRST CAUSE OF ACTION

Breach of Contract

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

62. Blue Cross and Does 1 through 100 owe duties and obligations to Plaintiffs and members of the Class under the health service plan contracts at issue.

63. By changing "annual" deductible and other "annual" and "yearly" benefits and out of pocket costs in the middle of the year, as well as unilaterally converting individual plan

contracts to month-to-month in duration and unilaterally amending the individual plan contracts to allow Blue Cross to change any term or benefit of the health service plans during the year on sixty days notice, Blue Cross and Does 1 though 100 have uniformly breached the terms and provisions of the individual plan contracts entered into with Plaintiffs and members of the Class.

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

SECOND CAUSE OF ACTION

Breach of the Duty of Good Faith and Fair Dealing

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

66. Defendant Blue Cross and Does 1 through 100 have breached their duty of good faith and fair dealing owed to Plaintiffs and members of the Class in the following respects:

a. Unreasonably and unilaterally increasing "annual" and "yearly" benefits and out of pocket costs under the Class members' individual plan contracts during the middle of the calendar year.

b. Unreasonably and unilaterally making changes to individual plan contracts that deny Class members the coverage and benefits that they had purchased for the entire year.

c. Unreasonably and unilaterally making changes to individual plan contracts that will lead to denials of Class members' claims for medical treatments as a result of Blue Cross's unreasonable reductions in coverage.

d. Unreasonably and unilaterally converting individual plan contracts to month-to-month in duration and unilaterally amending the individual plan contracts to allow Blue Cross to change the terms and benefits of individual plan contracts each month on sixty days notice.

67. Plaintiffs are informed and believe and thereon allege that Blue Cross and Does 1 though 100 have breached their duty of good faith and fair dealing owed to Plaintiffs and members of the Class by other acts or omissions of which Plaintiffs are presently unaware and

which will be shown according to proof at trial.

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

69. As a further proximate result of the unreasonable and bad faith conduct of Defendants, Plaintiffs 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 insurance contracts.

70. 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 Plaintiffs and members of the Class to punitive damages in an amount appropriate to punish or set an example of Defendants.

71. Defendants' conduct described herein was undertaken by Blue Cross'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 Blue Cross. Blue Cross further had advance 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 Plaintiffs at this time and are therefore identified and designated herein as Does 1 through 100.

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THIRD CAUSE OF ACTION

Declaratory Relief

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

73. 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."

74. 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 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 unilateral degradation of "annual" deductibles, benefits and other out of pocket costs in the middle of the year, as well as Blue Cross's unilateral conversion of individual plan contracts to month-to-month in duration and unilateral amendments to individual plan contracts purporting to allow Blue Cross to change any term or benefit each month on sixty days notice, are not authorized by the contracts between the class members and Blue Cross and Does 1 through 100. Defendants contend that their conduct was proper.

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

FOURTH CAUSE OF ACTION

Violation Civil Code § 1750, et seq. –

Consumer Legal Remedies Act

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

77. 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":

- "Inserting an unconscionable provision in the contract." (Civ. Code § 1770(a)(19).)
- "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).)

78. 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. Unilaterally adopting unconscionable and unenforceable terms in individual plan contracts. The unconscionable terms allow Blue Cross to unilaterally change "any term or benefit" of Plaintiffs' health service plans, including "annual deductibles" and other "annual" and "yearly" benefits, each month, and reduce the plan contract duration to month-to-month. Since the terms are both procedurally and substantively unconscionable they are unenforceable as a matter of law. The individual plan contract EOCs, August 2011 Endorsement, and the October 2011 Letter are procedurally and substantively unconscionable because:

i. The EOCs and endorsements are preprinted, standardized contracts of adhesion that are not subject to negotiation and are presented to customers after the individual plan contracts were entered into by Plaintiffs and Blue Cross.

ii. Acceptance of Blue Cross's terms and conditions lacks a modicum

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of bilaterality. Plaintiffs and Class members were presented with Blue Cross's terms and conditions on a take it or leave it basis with no ability to negotiate. As such, Plaintiffs and Class members had unequal bargaining power, no real negotiation, and an absence of meaningful choice.

iii. The terms of the February 2011 Letter, August 2011 Endorsement, and the October 2011 Letter render the individual health service plan contracts illusory, and thus are substantively unconscionable, because Blue Cross now may alter the individual plan contract terms to avoid paying for any health care services and unilaterally eliminate or undermine other benefits and terms.

b. Enforcing unconscionable and unenforceable terms and conditions against Class members, including terms and conditions that Class members never accepted or otherwise agreed to.

c. Representing that health service plans have "annual" and "yearly" characteristics and benefits which they do not have.

d. Representing that a transaction confers or involves "annual" and "yearly" rights, remedies, or obligations which they do not have.

e. Advertising health service plans as providing "annual" and "yearly" characteristics and benefits with the intent not to sell them as advertised.

79. 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 PPO health service plan contracts made and entered into by Blue Cross, Plaintiffs 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 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 in detail herein, or would have considered the omitted facts detailed herein material to their decisions to do so.

80. 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 "preferred provider" networks of hospital and doctors is the core of the PPO health service plans at issue here. But for the preferred provider networks, there would be no "PPO". 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: "Network – Quality. We work with our network doctors and hospitals, so you can get high-quality care at a low cost…." and, "Network – Choice. Our large networks mean you will likely find doctors that you know."[6] Blue Cross's "work and labor" to certify the "quality" of its health care providers and assure consumer "choice" are not available to consumers enrolled in "indemnity" health insurance policies.

- In order to access the key benefits of their PPO health service plans, a consumer must visit one of the preferred providers in Blue Cross's network. PPO consumers benefit from Blue Cross's "work and labor" to establish networks of high-quality hospitals and doctors, as co-payments and/or co-insurance are lower for in-network services.[7]

- 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 preferred 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.[8]

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[6] Blue Cross of California, http://www.anthem.com/ca/health-insurance/home/overview (last visited Feb. 6, 2013) (quoted text appears on the home page, slider 4 and 5.)

[7] See, e.g. Kassouf Complaint, Exhibit A, PPO Share $2,500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6; Kassouf Complaint, Exhibit B, PPO Share $1,500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6; Kassouf Complaint, Exhibit C, PPO Share $500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6. All plan documents were incorporated by reference into the Kassouf Complaint.

[8] See, e.g. Press Release, Anthem Blue Cross and Brotman Medical Center Reach Agreement, (Feb. 14, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1046; Press Release, Anthem Blue Cross, University of California Health Reach Agreement, (Jan. 17, 2012), available at

- 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.[9]

- 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

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

82. For purposes of the CLRA, "'[c]onsumer' means an individual who seeks or acquires, by purchase or lease, any goods or services for personal, family, or household purposes." (Civil Code § 1761 (d).) Here, Plaintiffs and Class Members are "consumers" because they obtained and renewed their individual contracts for the services in question for personal, family or household purposes.

83. Blue Cross violated the CLRA by committing unfair and deceptive acts that directly undermine Plaintiffs' and Class members ability to access the provider network. 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.

84. Plaintiffs and the Class members have suffered harm as a result of these violations. Plaintiffs purchased individual plan contracts, and renewed individual plan contracts, reasonably relying on Blue Cross's material misrepresentations, inter alia, that "annual" deductibles and other "annual" benefits and out of pocket costs would remain unchanged throughout the year and that the terms and benefits of their health service plans are not subject to unilateral monthly changes. 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

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http://www.anthem.com/ca/health-insurance/about-us/press-room/CA/2012; Girion, *Blue Cross, L.A. Hospitals Settle Dispute*, L.A. Times (Mar. 16, 2010), available at http://articles.latimes.com/2006/mar/16/business/fi-centinela16; Girion, *Blue Cross Coverage Extended in Dispute*, L.A. Times, (Feb. 25, 2006), available at http://articles.latimes.com/2006/feb/25/business/fi-centinela25.

[9] See, e.g. Press Release, Blue Cross of California, Anthem Blue Cross, University of California Health Form Alliance, (Nov. 13, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1198; Press Release, Blue Cross of California, Hospitals in Patient Safety First Collaborative Reduce Early Elective Deliveries by 65%, (Sept. 12, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1114;

customer service representatives in 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.

85. Plaintiffs have also suffered as a result of being subject to the unconscionable provisions reducing the contract term to just one month in duration. Defendants misrepresented and concealed these changes from Plaintiffs. Defendants do not have the right to enforce these contract terms.

86. 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.

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

88. 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.

89. 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.

90. Written notice pursuant to section 1782 of the CLRA was provided to Blue Cross by certified mail on or about January 6, 2012. As of the date of this First Amended Complaint, Blue Cross has failed to provide all requested relief in response to that notice. Therefore, Plaintiffs and Class members seek general, actual, consequential, punitive and statutory damages as well as equitable relief in the form of restitution of all monies paid for illegally decreased

benefits and increased out of pocket costs and/or for charges paid by Plaintiffs and Class members for decreased benefits, an injunction to prevent Blue Cross from illegally engaging in conduct as set forth above, disgorgement of the profits derived from Blue Cross's illegal business acts and practices, and all appropriate fees and costs as are permitted, including those permitted by Civil Code section 1780.

91. 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.

FIFTH CAUSE OF ACTION

Violation of Business & Professions Code § 17200 et seq. – Unlawful Business Acts and Practices

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

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

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

95. Blue Cross and Does 1 through 100 have violated and continue to violate Business & Professions Code section 17200's prohibition against engaging in "unlawful" business acts or practices, by, inter alia, violating Health and Safety Code section 1360 as set forth herein.

96. In relevant part, section 1360 bars Blue Cross from using any advertising or

solicitation "which is untrue or misleading, or any form of evidence of coverage which is deceptive." Moreover, under section 1360, 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."

97. Plaintiffs are informed and believe and on that basis allege that Blue Cross and Does 1 through 100 have violated section 1360 by:

a. Using deceptive EOCs, which purport to provide "annual deductibles" and other annual out of pocket costs and benefits.

b. Making representations about coverage offered by individual plan contracts that do not conform to fact.

c. Using advertising and solicitation methods, including representing that annual and "calendar year" deductibles, benefits, and out of pocket costs will remain unchanged throughout the calendar year, which are untrue or misleading.

98. In addition, Blue Cross and Does 1 through 100' unfair and unreasonable acts or practices violate 28 CCR section 1300.67.4, subdivision (a)(3)(A), and Health and Safety Code sections 1342 and 1367(h)(1).

99. In relevant part, 28 CCR section 1300.67.4, subdivision (a)(3)(A) provides that "[a] benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or copayment which renders the benefit illusory."

100. Blue Cross and Does 1 though 100 violated 28 CCR section 1300.67.4, subdivision (a)(3)(A) by carrying out unilateral mid-year changes to annual deductibles, benefits, and out of pocket costs and refusing to pay for otherwise covered benefits under individual plan contracts. Blue Cross's unilateral changes to the annual deductible have resulted in a moving target without any certainty of how much a consumer will have to pay out of pocket in any given calendar year, thus rendering the plan contracts illusory.

101. Additionally, Defendants have rendered the individual plan contracts illusory in violation of section 1300.67.4, subdivision (a)(3)(A) by making unilateral changes to the individual plan contracts that allow Defendants to increase out of pocket costs and change any

term or benefit of individual plan contracts each month. Specifically, under the terms of the August 2011 Endorsement and October 2011 Letter, individual plan contracts now "renew" each month when consumers pay their premium. According to the August 2011 Endorsement, Blue Cross may now change any contract terms and conditions of the individual plan contracts upon each monthly "renewal" following sixty days notice. Therefore, with the unilateral changes to the plan contracts outlined in the August 2011 Endorsement and October 2011 Letter Defendants have provided themselves the ability to ensure that consumers must pay otherwise covered health care costs out of pocket, thus rendering the plan benefits unfair, unreasonable, and illusory. Such acts impermissibly "transfer[] the financial risk of health care" from Blue Cross to consumers in contravention of the intent of the Knox-Keene Act.

102. Finally, Blue Cross's and Does 1 through 100's conduct also constitutes unlawful acts under the CLRA and Civil Code section 1670.5, which bar, inter alia, unconscionable contract terms.

103. Plaintiffs and class members have been injured by Blue Cross's and Does 1 though 100's unlawful business acts and practices resulting in the loss of money or property by, inter alia, receiving lesser coverage and benefits under their health plan contracts and/or paying increased annual deductibles and other annual out of pocket costs.

104. As a result of Blue Cross's and Does 1 through 100's violations of the Business & Professions Code section 17200, Plaintiffs and Class members are entitled to equitable relief in the form of full restitution of all monies paid for illegally reduced benefits and disgorgement of the profits derived from Blue Cross's unlawful business acts and practices.

105. Plaintiffs also seek an order enjoining Blue Cross from continuing its unlawful business practices and from such future conduct.

SIXTH CAUSE OF ACTION

Violation of Business & Professions Code § 17200 et seq. –

Unfair Business Acts and Practices

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

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

108. 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 conduct.

109. 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.

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

111. 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 the Knox Keene Act and regulatory provisions and their underlying purposes.

112. As a result of Blue Cross's and Does 1 though 100's violations of the Business & Professions Code section 17200, Plaintiffs and Class members are entitled to equitable relief in the form of full restitution of all monies paid for decreased benefits and disgorgement of the profits derived from Blue Cross's unfair business acts and practices.

113. Plaintiffs also seek an order enjoining Blue Cross and Does 1 through 100 from such future conduct.

SEVENTH CAUSE OF ACTION

Violation of Business & Professions Code § 17200 et seq. –

Fraudulent Business Acts and Practices

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

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

116. As more fully described herein, Defendants' misleading and fraudulent statements in EOCs, the February 2011 letter, the August 2011 Endorsement, October 2011 Letter, and

advertising, marketing and communications are likely to deceive reasonable California consumers. Plaintiffs and other members of the Class were unquestionably deceived regarding the "annual" nature of plan contract out of pocket costs, other "annual" benefits, as well as the duration of the individual plan contracts. Blue Cross's misrepresentations 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.

117. These acts and practices resulted in and caused Plaintiffs and Class members to pay more for insurance and accept lesser benefits than they would have absent Defendants' fraud.

118. Plaintiffs and class members have been injured by Defendants' fraudulent business acts and practices by receiving lesser benefits under their individual plan contracts.

119. As a result of Defendants' violations, Plaintiffs and Class members are entitled to equitable relief in the form of full restitution of all monies paid for decreased benefits and disgorgement of the profits derived from Defendants' fraudulent business acts and practices.

120. Plaintiffs also seek an order enjoining Defendants from such future conduct.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on their own behalf and on behalf of the Class, pray for relief as follows, as applicable to the causes of action set forth above:

1. An Order certifying the proposed Class pursuant to Code of Civil Procedure section 382 and Civil Code section 1780 et seq. and appointing Plaintiffs to represent the proposed Class and designating their counsel as Class Counsel;

2. An Order enjoining Blue Cross from future breaches of their individual plan contracts and violations of the Health and Safety Code section 1360, 28 CCR section 1300.67.4 subdivision (a)(3)(A), Business & Professions Code section 17200 et seq., Civil Code section 1670.5, and the CLRA as alleged herein;

3. An Order declaring the rights and obligations of the parties under the individual plan contracts at issue;

4. An Order awarding Plaintiffs and the Class damages for failure to provide benefits 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 Plaintiffs and the Class punitive and exemplary damages in an amount appropriate to punish or set an example of defendants;

6. An Order awarding Plaintiffs and the Class restitution and/or disgorgement and such other relief as the Court deems proper; and,

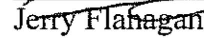
7. An Order awarding Plaintiffs' attorneys' fees, expert witness fees and other costs.

JURY DEMAND

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

DATED: March 22, 2013

Respectfully Submitted,
Harvey Rosenfield
Pamela Pressley
Jerry Flanagan
CONSUMER WATCHDOG

By: 
Jerry Flanagan
Attorneys for Plaintiffs

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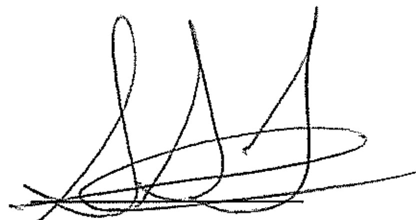
AFFIDAVIT

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 Janet Kassouf, Alison Heath, and David Jacobson 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 First Amended 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 22 day of March 2013, at Santa Monica, California.



JERRY FLANAGAN

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PROOF OF SERVICE
[BY OVERNIGHT OR U.S. MAIL, FAX TRANSMISSION, EMAIL TRANSMISSION AND/OR PERSONAL SERVICE]

State of California, City of Santa Monica, County of Los Angeles

I am employed in the City of Santa Monica and County of Los Angeles, State of California. I am over the age of 18 years and not a party to the within action. My business address is 2701 Ocean Park Blvd., Suite #112, Santa Monica, California 90405, and I am employed in the city and county where this service is occurring.
On March 22, 2013 I caused service of true and correct copies of the document entitled

- **FIRST AMENDED CLASS ACTION COMPLAINT AND AFFIDAVIT; and**
- **EXHIBITS A-H TO PLAINTIFFS' FIRST AMENDED CLASS ACTION COMPLAINT**

upon the persons named in the attached service list, in the following manner:

1. If marked FAX SERVICE, by facsimile transmission this date to the FAX number stated to the person(s) named.

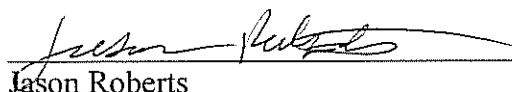
2. If marked EMAIL, by electronic mail transmission this date to the email address stated.

3. If marked ELECTRONIC SERVICE, by Lexis Nexis File & Serve through electronic transmission to all parties appearing on the electronic service list. Upon completion of said transmission of said document, a certified receipt is issued to the filing party acknowledging receipt by Lexis-Nexis system. Once Lexis-Nexis has served all designated recipients, proof of electronic service/confirmation will be maintained with the original document in this office.

4. If marked U.S. MAIL or OVERNIGHT or HAND DELIVERED, by placing this date for collection for regular or overnight mailing true copies of the within document in sealed envelopes, addressed to each of the persons so listed. I am readily familiar with the regular practice of collection and processing of correspondence for mailing of U.S. Mail and for sending of Overnight mail. If mailed by U.S. Mail, these envelopes would be deposited this day in the ordinary course of business with the U.S. Postal Service. If mailed Overnight, these envelopes would be deposited this day in a box or other facility regularly maintained by the express service carrier, or delivered this day to an authorized courier or driver authorized by the express service carrier to receive documents, in the ordinary course of business, fully prepaid.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 22, 2013, at Santa Monica, California.



Jason Roberts

SERVICE LIST

Person Served	**Method of Service**
Kurt C. Peterson Kenneth N. Smersfelt Amir Shlesinger REED SMITH LLP 355 South Grand Avenue, Suite 2900 Los Angeles, CA 90071-1514 Tel. No.: (213) 457-8000 Fax No.: (213) 457-8080 Kpeterson@ReedSmith.com KSmersfelt@ReedSmith.com AShlesinger@ReedSmith.com	_______ FAX _______ U.S. MAIL _______ OVERNIGHT MAIL _______ HAND DELIVERED ___X___ EMAIL ___X___ ELECTRONIC SERVICE
Michael J. Bidart Ricardo Echeverria SHERNOFF BIDART DARRAS & ECHEVERRIA 600 South Indian Hill Boulevard Claremont, CA 91711 Tel. No.: (909) 621-4935 Fax No.: (909) 625-6915 Mbidart@Shernoff.com Recheverria@Shernoff.com	_______ FAX _______ U.S. MAIL _______ OVERNIGHT MAIL _______ HAND DELIVERED ___X___ EMAIL ___X___ ELECTRONIC SERVICE