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Superior Court of California
County of Los Angeles

SEP 23 2014

Sherri R. Carter, Executive Officer/Clerk
By Myrna Beltran, Deputy

SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

BC 558549

KEVIN & JANE MCCARTHY, SALLY GREER, TIEMO MEHNER & CYNTHIA CARLSON, individually and on behalf of all others similarly situated; Plaintiffs, v. CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA; and DOES 1 through 100 inclusive, Defendants.	Case No.: <u>CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL</u> 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

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Remedies Act, Civil Code § 1750, et seq.
6. Breach of Contract
7. Breach of the Implied Covenant of Good Faith and Fair Dealing
8. Declaratory Relief

Plaintiffs Kevin and Jane McCarthy, Sally Greer, Tiemo Mehner and Cynthia Carlson (collectively, "Plaintiffs"), by their attorneys, bring this action on behalf of themselves and all others similarly situated against defendant California Physicians' Service dba Blue Shield of California (hereafter, "Blue Shield"). Plaintiffs allege the following on information and belief, except as to those allegations which pertain to the named Plaintiffs, which are alleged on personal knowledge:

NATURE OF THE ACTION

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

- Misrepresented, and continues to misrepresent, to consumers that their physicians and hospitals are participating in Blue Shield health service plans;
- Subjected, and continues to subject, Plaintiffs and Class Members to inadequate networks of physicians and hospitals, causing delays and interruptions in accessing needed health care;
- Delayed Class Members' enrollment in new health service plans for months, effectively blocking access to physician and hospital services, even though Blue Shield collected consumers' premiums; and,
- Subjected consumers to exceedingly long wait times, regularly lasting several hours, on customer service telephone lines when consumers called to address these problems and misrepresentations.

2. In late 2013, to coincide with the commencement of federal health reform, the Affordable Care Act (hereafter, "ACA"), Blue Shield canceled its existing non-ACA-compliant health service plans and made available to California consumers new health service plans effective January 1, 2014.

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

4. Blue Shield represented and marketed its health service plans as having specific physicians and hospitals (hereafter, "providers") available to consumers enrolled in those plans (hereafter, "provider networks").

5. Prior to purchasing new health service plans on the Covered California exchange or directly from Blue Shield, Plaintiffs and Class Members checked with Blue Shield over the phone, on Blue Shield's website, and with their providers to make sure that their providers were in-network under the Blue Shield plan that they were considering purchasing. In reliance on Blue Shield's representations and omissions regarding provider networks, Plaintiffs and Class Members purchased Blue Shield plans.

6. Blue Shield offered Exclusive Provider Organization ("EPO") and Preferred Provider Organization ("PPO") plans inside and outside the Covered California exchange during the Open Enrollment Period. An EPO plan, like an HMO, only covers the cost of a visit with a provider within the plan's network and provides no coverage for out-of-network, non-emergency services. A PPO plan allows enrollees to visit pre-specified, in-network providers at a discount, but also covers some portion of out-of-network provider services.

7. Prior to meeting their annual deductible, patients seeking services from in-network providers would benefit from reduced costs for services that are the result of pre-negotiated fee schedules resulting from agreements entered into between Blue Shield and in-network providers. Patients who visit out-of-network providers do not get the benefit of these negotiated fee schedules and must pay the amount billed by the provider.

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8. Once enrollees have met their plan's annual deductible, they will share the cost of services with Blue Shield. Enrollees can either share the cost through a co-payment, which is a fixed dollar amount, or through co-insurance, which is a percentage of the amount listed on Blue Shield's negotiated fee schedule for that provider.

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

- Promised providers are not in-network;
- Negotiated fee schedules are not available;
- Payments made to out-of-network providers do not accrue toward Plaintiffs' and Class Members' annual deductible; and
- Payments made to out-of-network providers do not accrue toward Plaintiffs' and Class Members' annual out-of-pocket limit.

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

11. Furthermore, these practices improperly shift the cost of medical care onto Plaintiffs and Class Members. For those with PPO plans, the reduced networks can transform fixed co-payments into percentage-based co-insurance arrangements that can leave enrollees

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on the hook for hundreds of additional dollars. For enrollees with EPO plans, a visit with an out-of-network provider will come entirely out of the enrollee's pocket.

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

13. By selling health service plans that do not provide benefits or access to physicians and hospitals as advertised and by not delivering ID cards upon consumers' payment of premium, Blue Shield's deceptive business practices resulted in mass confusion. Plaintiffs and Class Members who call Blue Shield's customer service telephone line seeking information about the loss of benefits and limited provider networks spend hours navigating through a labyrinth of automated phone trees, multiple transfers, average hold times of two to three hours, and disconnections.

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

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

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

17. Blue Shield's bait and switch tactics of representing and advertising that its health service plans have certain providers in the plans' networks when those providers are

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not actually in the plans' networks violates the Consumers Legal Remedies Act (hereafter, "CLRA"), California Civil Code section 1750, et seq.

18. Finally, through its conduct of misrepresenting provider networks and failing to provide proof of insurance to consumers, Blue Shield 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.

19. Plaintiffs seek to recover damages resulting from Blue Shield's breach of contract and breach of the implied covenant of good faith and fair dealing; an order of this Court enjoining Blue Shield's continued violations; an order for restitution of all monies paid for Blue Shield health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards; and other remedies as set forth herein.

PARTIES

20. Plaintiffs Kevin and Jane McCarthy (McCarthys) are citizens of California and reside in Ventura County.

21. Plaintiff Sally Greer (Greer) is a citizen of California and resides in Orange County.

22. Plaintiffs Tiemo Mehner (Mehner) and Cynthia Carlson (Carlson) are citizens of California and reside in Los Angeles County.

23. Defendant California Physicians' Service dba Blue Shield of California is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in San Francisco, California. It is authorized to conduct business as a health care service plan and transacts, and is transacting, the business of providing health plans to consumers throughout this State.

24. The true names and capacities, whether individual, corporate, associate or

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otherwise, of defendants Does 1 through 100 are unknown to Plaintiffs, who therefore sue these defendants by such fictitious names. Plaintiffs allege upon information and belief that 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.

25. At all relevant times, Blue Shield 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

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

27. This Court has jurisdiction over Blue Shield, a resident of the State of California.

28. Jurisdiction over Blue Shield is also proper because Blue Shield has purposely availed itself of the privilege of conducting business activities in California and because Blue Shield 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 Blue Shield.

29. 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.

30. Venue is proper in this Court because, inter alia, Blue Shield engages and performs business activities in the County of Los Angeles, substantial transactions took place in the County of Los Angeles, Blue Shield has received substantial profits from consumers

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who reside in the County of Los Angeles, and because Plaintiffs Mehner and Carlson reside in Los Angeles County and entered into agreements to purchase Blue Shield's health service plan while in the County of Los Angeles.

STATUTORY AND REGULATORY SCHEME

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

32. Individuals could purchase health service plans through their state's exchange during the six-month Open Enrollment Period between October 1, 2013 and March 31, 2014. (45 C.F.R. § 155.410.) Individuals could also purchase health service plans directly from health plans during the Open Enrollment Period. 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).)

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

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

35. 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

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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).)

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).)

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

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

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

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

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subscriber, in a plan, and such is not the case." (*Id.* at (a)(2).)

38. The Knox-Keene Act also requires a health care service plan to "provide, upon request, a list of … contracting providers, within the enrollee's or prospective enrollee's general geographic area" including a list of "[p]rimary care providers." (Health & Saf. Code § 1367.26(a)(1).) "A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet Web site . . . ." (*Id.* at (d).)

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

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

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

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

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

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

e. Plans must ensure that primary health care service facilities are available to enrollees "within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility." (28 C.C.R. § 1300.67.2(a); see 28 C.C.R. § 1300.67.2.1; 20 C.C.R. § 1300.51(c)(H).) For example, health service plans must ensure that "[a]ll enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees." (20 C.C.R. § 1300.51(c)(H)(i).)

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

41. To further the goals of ensuring the best possible health care for the public at the lowest possible cost, the Knox-Keene Act provides that a health care service plan, at the request of an enrollee, must arrange the completion of covered services by a terminated provider or by a nonparticipating provider for an acute condition, serious chronic condition, pregnancies, terminal illness, care of a newborn child, or performance of surgery. (Health & Saf. Code § 1373.96(a)-(c), (l), (m)(2).) "A health care service plan … shall furnish services

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

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in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.” (Health & Saf. Code § 1367(d).)

FACTUAL ALLEGATIONS

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

42. At the end of 2013, in anticipation of the changes required by the ACA, Blue Shield canceled all non-ACA-compliant plans it offered in California and began offering new ACA-compliant plans to consumers during the Open Enrollment Period, October 1, 2013 through March 31, 2014.

43. Blue Shield offered PPO and EPO health service plans throughout California during the Open Enrollment Period.

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

B. Blue Shield intentionally misrepresented its provider networks—concealing that its new networks were significantly more limited than its previous networks.

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

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

47. The networks of Blue Shield providers available to Plaintiffs and Class Members are drastically more limited than the networks of providers available to Blue Shield

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enrollees prior to the ACA. Blue Shield intentionally failed to update its provider lists, and allowed the outdated provider information to be disseminated to potential enrollees in order to make its new health service plans appear to have broader coverage and benefits than they really did. Blue Shield knew that many of the potential customers would check to ensure that certain providers were listed as participating in Blue Shield's networks before selecting a new ACA-compliant health service plan. Therefore, Blue Shield intentionally disseminated inaccurate provider lists during this crucial Open Enrollment Period so that potential customers would purchase the plans.

48. Hundreds of thousands of enrollees who purchased Blue Shield plans are learning that during the Open Enrollment Period they were provided inaccurate information, either over the phone (and therefore subjected to excessive wait times), on Blue Shield's website, or on the Covered California website. As a result, hundreds of thousands of enrollees have sought treatment from providers that were listed as in-network—only to later have their claims denied based on these inaccurate representations and the newly reduced networks.

49. In addition to Blue Shield's misrepresentations on the Internet and over the phone, Blue Shield's marketing, sales, and plan informational materials concealed the nature of its new ACA-compliant plans. Rather than offer its traditional Blue Shield network to individual enrollees, Blue Shield offered a much more restrictive "Exclusive PPO Network" for its PPO plans and an "Exclusive EPO Network" for its EPO plans. Blue Shield's sales and marketing materials led consumers to believe that the only changes Blue Shield made to its older health service plans were changes to ensure compliance with ACA requirements.

C. Kevin and Jane McCarthy were fraudulently induced into purchasing a Blue Shield health service plan with a drastically reduced network of providers.

50. Near the end of 2013, Kevin and Jane McCarthy received a notice from their insurer, Aetna, that their existing individual health service plan was being canceled because the company was withdrawing all of its individual health service plans from the California

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market. Kevin and Jane started shopping for a new health service plan.

51. It was important to Kevin and Jane that Jane's physician of over ten years, Dr. Jody Levy, and Kevin's longtime physician, Dr. Sima Yaftali, were both in-network under their new health service plan.

52. Jane researched the health service plans available in Ventura County where she and Kevin reside. She learned that only three companies, including Blue Shield, offered health service plans in Ventura County.

53. Jane visited Blue Shield's website and used Blue Shield's provider search tool, which listed both Dr. Levy and Dr. Yaftali as in-network providers under Blue Shield's "Silver Enhanced PPO" plan.

54. Jane called Dr. Levy and Dr. Yaftali and they both confirmed that they would accept Blue Shield's "Silver Enhanced PPO" plan.

55. Based on Blue Shield's representations that Dr. Levy and Dr. Yaftali were in-network, the McCarthys decided to enroll in the "Silver Enhanced PPO" health service plan in December 2013.

56. Blue Shield's Silver Enhanced PPO has an annual deductible of $2,000 per individual. This means that Kevin and Jane must each pay $2,000 out-of-pocket before Blue Shield will begin to pay for covered services. Under their plan, payments Kevin and Jane make to out-of-network providers do not count toward satisfying their individual $2,000 annual deductibles. If they ever meet their annual deductibles, Blue Shield will only cover 50% of the cost of a covered service from an out-of-network provider.

57. Also, Blue Shield's Silver Enhanced PPO has two out-of-pocket limit amounts: for in-network provider services, the out-of-pocket limit is $6,350 per individual; for out-of-network provider services, the out-of-pocket limit is $9,350 per individual. The out-of-pocket limit is the most an enrollee should expect to pay out-of-pocket annually. Under their plan, payments Kevin and Jane make to out-of-network providers do not count toward their individual $6,350 in-network, out-of-pocket limit amounts.

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58. In late March 2014, Kevin visited Dr. Yaftali for routine medical tests.

59. Kevin subsequently received an Explanation of Benefits ("EOB") from Blue Shield for his March 2014 visit to Dr. Yaftali, which listed Dr. Yaftali as out-of-network. The EOB therefore showed that Blue Shield was only covering $16.46 of the $100 bill (a small portion relating to the type of service Kevin received) and that Kevin was responsible for paying the remaining $83.54 out-of-pocket, and none of that amount would be applied to satisfy his deductible or accrue toward his $6,350 out-of-pocket limit.

60. Kevin and Jane both called Blue Shield many times to inquire about the out-of-network charges for Kevin's visit with Dr. Yaftali. Each time they called Blue Shield, they experienced hold times lasting two to four hours. Because of these excessive hold times, Kevin and Jane had to schedule blocks of time where they would stop running their small business in order to call Blue Shield to ask about the out-of-network charges. Kevin and Jane lost business as a result of the time they spent on hold with Blue Shield.

61. When Kevin and Jane were able to connect to live Blue Shield customer service representatives, they received inconsistent information. During one phone call, a representative assured Jane that Dr. Yaftali was an in-network provider. But, during a later phone call, Blue Shield said that Dr. Yaftali was not in-network. During these phone calls, Blue Shield told Jane that Dr. Levy was no longer in-network under their PPO plan.

62. Kevin subsequently returned to the Blue Shield website, which no longer listed Dr. Yaftali as an in-network provider.

63. Eventually, Kevin connected with a Blue Shield representative over the phone who said that Blue Shield would cover 50% of Kevin's March 2014 bill for Dr. Yaftali, but that this was a "one-time" offer.

64. Kevin considered switching to a different provider who was in-network under his Blue Shield plan. According to Blue Shield's website, however, the nearest in-network providers were located in another county more than 30 miles away.

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65. In early May 2014, Kevin saw Dr. Yaftali for a follow-up appointment. Kevin later received an EOB from Blue Shield showing that he was responsible for charges from his appointment with Dr. Yaflati at the out-of-network rate. Kevin paid these charges out-of-pocket.

66. Kevin filed a grievance with Blue Shield on May 7, 2014, requesting that Blue Shield cover services from Dr. Yaftali and Dr. Levy at the in-network rate. Blue Shield responded with a letter that said Blue Shield's Enhanced PPO's network consisted of a "selected network" of providers and Dr. Yaftali and Dr. Levy were not within this "selected network."

67. On June 3, 2014, Jane visited a neurologist because of her chronic migraines. Before Jane had scheduled this appointment, she confirmed with a Blue Shield customer service agent that this neurologist was an in-network provider. However, the neurologist told Jane during the visit that the office no longer accepted Jane's Blue Shield health service plan. No provider in the entire medical center where the neurologist worked accepted Jane's Blue Shield health service plan. Jane paid for this visit out-of-pocket.

68. Kevin and Jane have incurred and continue to incur hundreds of dollars in medical bills for Dr. Yaflati, Dr. Levy and other out-of-network providers that Blue Shield previously represented as in-network.

D. Sally Greer was fraudulently induced into purchasing a Blue Shield health service plan with a drastically reduced network of providers.

69. In October of 2013, Sally enrolled in a Blue Shield Silver PPO individual health service plan through the Covered California health insurance exchange. The eligibility date for the plan was January 1, 2014.

70. In or about December of 2013, Sally checked the provider search function of Blue Shield's website and confirmed that health care providers at the University of California Irvine ("UCI") were in-network providers for the plan in which she enrolled. She also checked the website and confirmed that a particular UCI infectious disease doctor, Dr.

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Catherine Diamond, was an in-network provider. It is and was important to Sally that these doctors are in-network providers as they are geographically close to where she lives and because her previous doctors recommended the UCI providers as the doctors believe that the UCI doctors have the best resources available to treat Sally's existing ailments and medical conditions.

71. During December of 2013, Sally attempted to call Blue Shield to confirm that coverage under her Blue Shield plan would begin on January 1, 2014 and that her first payment had been accepted. It took her numerous calls that spanned multiple hours before she reached a Blue Shield representative who was able to provide her with the confirmation that she sought.

72. In January of 2014, Sally went on Blue Shield's website and again confirmed that the infectious disease doctor, Dr. Catherine Diamond, from whom she wanted to seek treatment was an in-network provider. Relying upon this information, Sally visited Dr. Diamond for treatment in early February of 2014. Unfortunately, this doctor was not an actual in-network provider for Sally's Blue Shield health plan and UCI was not a contracted in-network facility. As a result, Sally is now responsible for costs of the services that she otherwise would not have to pay had the doctor held the in-network provider status that Blue Cross claimed the doctor held.

73. Sally also incurred additional bills as a result of Blue Shield's misrepresentations. After Sally's appointment, Dr. Diamond referred Sally to see another UCI doctor whom she saw in February of 2014 and who subsequently referred Sally to physical therapy and to two specialists at UCI's eye institute. Shortly after, Sally saw the two UCI specialists, had blood work conducted and made an appointment for physical therapy at UCI. Unfortunately, despite Blue Shield's representations to the contrary, these healthcare professionals also were not in-network providers and as a result, Sally has incurred out-of-pocket costs for their services and had to cancel future appointments for necessary treatments.

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E. Tiemo Mehner and Cynthia Carlson paid premiums for months and never received their enrollment ID cards.

74. In early December 2013, Tiemo Mehner and Cynthia Carlson signed up for the "Blue Shield – Bronze 60 PPO" individual health service plan through the Covered California exchange website.

75. On December 30, 2013, Tiemo and Cynthia received a letter from Blue Shield, dated December 20, 2013, informing them that their application for health coverage had been received and that they should make a payment by December 21, 2013 to complete enrollment. Tiemo immediately made a payment via credit card on Blue Shield's website, and his card was charged for the payment on January 2, 2014.

76. In a letter dated January 7, 2014, Blue Shield stated "[y]our coverage effective date is January 1, 2014." Blue Shield also stated, "Please note that ID cards and certificates will be sent under separate cover." As of the end of January 2014, Tiemo and Cynthia still had not received ID cards.

77. On February 19, 2014, Tiemo and Cynthia received a letter from Blue Shield, dated February 8, 2014, telling them that Blue Shield had not received their payment and "immediate action is needed … [i]f you would like to continue your coverage(s)[.]" Tiemo immediately sent a payment by check, and Blue Shield deposited the check on February 26, 2014. As of the end of February 2014, Tiemo and Cynthia still had not received ID cards.

78. In a letter dated March 7, 2014, Blue Shield again told Tiemo and Cynthia that it had not received their payment and "immediate action is needed … [i]f you would like to continue you coverage(s)[.]"

79. Tiemo then called Blue Shield and received an automated confirmation that Blue Shield had received all payments and that no payments were due. Still concerned, Tiemo called Blue Shield to try and speak with a live customer service representative. After approximately 80 minutes on hold, Tiemo reached a live representative who confirmed that Blue Shield had received Tiemo and Cynthia's payments and said that there had been an error

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in the system that Blue Shield was working to correct.

80. As of the end of March 2014, Tiemo and Cynthia still had not received ID cards. Tiemo and Cynthia also never received an invoice for their March 2014 premium payment.

81. On April 19, 2014, Tiemo and Cynthia received a letter from Blue Shield informing them that their coverage "has been terminated as of February 28, 2014 because we did not receive your premium payment." Tiemo immediately called Blue Shield's customer service telephone line and, after being on hold for 40 minutes, Blue Shield suddenly played an automated message instructing Tiemo to call back during business hours and disconnected the call.

82. The next day, Tiemo called a different insurance company, Anthem Blue Cross, to get information about switching health plans. Blue Cross told Tiemo that coverage was not available to Tiemo and Cynthia because their previous health service plan had been terminated due to nonpayment. According to Blue Cross, they could not purchase coverage until the next enrollment period.

83. Left with no alternative, Tiemo called Blue Shield on April 21, 2014 to try and reinstate his and Cynthia's health service plan. Tiemo was on hold for approximately 45 minutes before he connected to a live representative, who confirmed that Blue Shield had received the February 2014 payment. The representative told Tiemo that he would be contacted by Blue Shield's "Reinstatement Department" within five days, and Tiemo would have to pay the accrued balance for their March, April, and May 2014 premiums in order to reinstate coverage.

84. Having heard nothing from the Reinstatement Department, on April 30, 2014, Cynthia called Blue Shield. Cynthia was on hold for 50 minutes before she connected to a live representative, who told Cynthia that an error had occurred in the Reinstatement Department. When Cynthia then tried to make a payment for their March, April, and May 2014 premiums, the Blue Shield representative said she could not process the payment and would call Cynthia

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back. Cynthia never heard from the Blue Shield representative.

85. As of the end of April 2014, Tiemo and Cynthia still had not received ID cards. Tiemo and Cynthia also never received an invoice for their April 2014 premium payment.

86. On May 1, 2014, Cynthia called Blue Shield again to inquire about their coverage. After waiting on hold for 55 minutes, a customer service representative promised to expedite Tiemo and Cynthia's claim with the Reinstatement Department.

87. On May 14, 2014, Cynthia spoke with a Covered California customer service representative who assured Cynthia that she and Tiemo would not have to pay penalties under the ACA due to a lapse in coverage, since Blue Shield erred in processing their payments. The Covered California representative started the paperwork to get Tiemo and Cynthia's coverage "reinstated" with Blue Shield. Cynthia was instructed to follow up with Blue Shield.

88. Cynthia called Blue Shield and waited on hold for 20 minutes before Blue Shield's telephone system disconnected the call.

89. Cynthia called Covered California and terminated the Blue Shield health service plan for misrepresentation and incompetence. Tiemo and Cynthia enrolled in an equivalent Health Net plan.

90. During this time, Cynthia needed to visit a doctor for her annual checkup. She refrained from getting the checkup because she had not received her ID card.

91. Tiemo and Cynthia were never reimbursed by Blue Shield for the premium payments Blue Shield accepted without providing them proof of coverage.

SUMMARY OF BLUE SHIELD'S ILLEGAL ACTS

92. As discussed in more detail herein, through its conduct of misrepresenting provider networks, failing to complete enrollment and provide proof of coverage to consumers in a timely manner, and operating a telephone customer service call center where consumers are unable to obtain information due to long hold times and technical difficulties, Blue Shield:

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- Violated Health and Safety Code section 1360, which bars companies providing health service plans from using any advertising or solicitation that is untrue or misleading. Blue Shield's misrepresentations and untrue statements about the providers included in its individual health service plan networks violate Health and Safety Code section 1360.

- Violated Health and Safety Code section 1367.26, which requires health care service plans to furnish provider lists to consumers upon request. Blue Shield's incorrect provider lists and inaccurate provider search tool on Blue Shield's website violate Health and Safety Code section 1367.26.

- Violated a provision of the California Code of Regulations requiring that "the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." (28 CCR § 1300.67.2.2(c)(10).)

- Violated provisions of the Health and Safety Code and California Code of Regulations requiring that health service plans have sufficient provider networks to ensure the provision of covered health care services in a timely manner and within a reasonable proximity to enrollees. (Health & Saf. Code § 1367.03(f)(1), 28 CCR § 1300.67.2.2, 28 C.C.R. § 1300.67.2(a); see 28 C.C.R. § 1300.67.2.1; 20 C.C.R. § 1300.51(c)(H).)

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

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

93. Blue Shield engaged in various unfair and deceptive acts in violation of the CLRA by:

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

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

- Representing and advertising that its health service plans provide coverage for services

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rendered by a network of certain providers and then announcing the network of providers had changed after the Open Enrollment Period closed in violation of Civil Code section 1770, subdivision (a)(14).

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

CLASS ALLEGATIONS

94. 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 and Civil Code section 1781. Plaintiffs seek to represent the following class:

> All current California residents who enrolled in an individual Blue Shield health service plan between October 1, 2013 through and including March 31, 2014 and (i) whose health service plan provider network was misrepresented, or (ii) who were provided inadequate networks of physicians and hospitals causing delays and interruptions in accessing needed health care; or (iii) whose enrollment was not completed in a timely manner thereby depriving them of access to coverage they purchased, or (iv) who were subjected to excessive hold times and delays on customer service telephone lines.

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

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

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

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

99. 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

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the Class.

100. The self-interests 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.

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

102. 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 Shield.

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

104. 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.

105. Plaintiffs do 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

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

107. 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 . . . ."

108. Blue Shield's conduct, and the conduct of Does 1 through 100, as described

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above, constitutes unlawful business acts and practices.

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

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

a) misrepresenting or concealing that its new individual health service plans only provide access to a drastically reduced network of providers rather than the provider network Blue Shield had previously offered its plan members;
b) concealing that Plaintiffs and Class Members only had access to a new, extremely narrow network of providers;
c) misrepresenting and intentionally disseminating an inaccurate provider list to existing and potential customers with knowledge this information was inaccurate; and
d) misrepresenting that Plaintiffs and Class Members would receive coverage under their new ACA-compliant plans upon payment of premium to Blue Shield.

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

c. By failing to direct Plaintiffs and Class Members to an accurate,

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

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

e. By misrepresenting the providers that would be in-network under Plaintiffs' and Class Members' plans and consequently forcing Plaintiffs and Class Members to forego care and/or seek new providers, Blue Shield has failed to "establish and maintain provider networks" that provide services to enrollees "in a timely manner consistent with good professional practice" in violation of 28 CCR § 1300.67.2.2(c)(1).

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

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

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h. By failing to provide Plaintiffs and Class Members with "a contracting or plan-operated primary care provider" "within 30 minutes or 15 miles" of their residences or workplaces, Blue Shield is failing to ensure that primary health care service facilities are located "within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility" in violation of 28 C.C.R. § 1300.67.2(a), 28 C.C.R. § 1300.67.2.1, and 20 C.C.R. § 1300.51(c)(H).

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

j. By collecting premium payments from Plaintiffs and Class Members without initiating coverage such that they cannot access benefits under their individual health service plan contracts, Blue Shield is failing to provide "contracts with subscribers and enrollees" that are "fair, reasonable, and consistent with the objectives of [the Knox-Keene Act]" in violation of Health and Safety Code section 1367, subdivision (h)(1).

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

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

111. Plaintiffs and Class Members have suffered injury in fact and lost money

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and/or property as a result of Blue Shield'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 unexpected out-of-pocket costs and inflated premiums, and/or paying out-of-pocket costs and premium amounts in excess of what a Class Member would have paid if Defendants had accurately disclosed the health service plans' provider networks.

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

SECOND CAUSE OF ACTION

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

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

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

115. 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 Shield's and Does 1 through 100's conduct.

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

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

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

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

THIRD CAUSE OF ACTION

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

Fraudulent Business Acts and Practices

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

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

122. Defendants' misleading and fraudulent representations, advertising, marketing, and communications are likely to deceive reasonable California consumers. Plaintiffs and other members of the Class were unquestionably deceived regarding the provider networks and Blue Shield's other misrepresentations and omissions as more fully described herein.

123. Blue Shield's misrepresentations and omissions were material and were a substantial factor in Plaintiffs' decisions to enroll in and renew their health service plan

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contracts. Such acts are fraudulent business acts and practices.

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

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

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

FOURTH CAUSE OF ACTION

Violations of the California False Advertising Law,

Business & Professions Code § 17500, et seq.

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

128. 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.

129. These representations have deceived and are likely to deceive Plaintiffs and Class Members in connection with their decision to purchase their individual health service plan contracts. Defendants' representations also have deceived and are likely to deceive Plaintiffs and Class Members with respect to the expected costs they would be spending out-of-pocket under their individual health care service plan contracts. Defendants'

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representations were material and were a substantial and material factor in Plaintiffs' decisions to purchase their health service plans. Had Plaintiffs known the actual facts, they would not have purchased the health service plans and paid out-of-pocket costs and premiums in excess of what they would have paid if Defendants had accurately disclosed provider networks and the real terms, coverage and benefits provided by the health service plans.

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

131. 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.

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

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

FIFTH CAUSE OF ACTION

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

134. Plaintiffs incorporate by reference each of the preceding paragraphs as though

fully set forth herein.

135. 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).)

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

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

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

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

d. Adopting unconscionable contract provisions requiring undisclosed higher deductible limits for out-of-network providers, adopting inadequate provider networks,

and concealing material terms of the coverage.

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

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

- Blue Shield advertises its EPO and PPO coverage by promoting the network services it provides and the "work and labor" Blue Shield expends in order to guarantee quality and provide consumer choice. Blue Shield's website promises consumers: "easy access to a broad range of doctors, specialists and hospitals. Our providers meet

stringent credentialing standards and include some of the most prestigious hospitals in the state … We actively help our members find access to quality care in a variety of ways." Blue Shield's "work and labor" to certify the "quality" of its health care providers is not available to consumers enrolled in indemnity health insurance policies.

- The central purpose of the EPO and PPO contracts between Blue Shield and Class members is Blue Shield's provision of work, labor and services in connection with establishing and maintaining on-going access to its network of "preferred providers," which include doctors and hospitals throughout the state. In order to access the key benefits of the health service plan contracts, a consumer must pay a monthly rate to Blue Shield and visit one of the preferred providers in Blue Shield's network. For example, ". . . Blue Shield [] contracts with each individual preferred provider physician to accept those fixed fees as payment in full" for medical care provided to PPO enrollees (Gasparovich, Preferred Provider Organizations Providing Contracting: New Analysis Under the Sherman Act (1985) 37 Hastings L.J. 377, 380, emphasis added). "Under Blue Shield's preferred provider plans, a preferred provider is prohibited from engaging in any balance billing to the patients, and any co-payment received from the patient, as required for certain services, is deducted from the contract-specified fee." (*Id.*)

- Blue Shield's work and labor to maintain those networks require Blue Shield to engage in substantial contract negotiations with physician groups and hospitals that can last more than a year, causing worry and confusion for thousands of patients seeking ongoing treatment from those providers and who would be required to "pay significantly more for services from non-preferred providers" if contract disputes are not resolved. (*Rubinstein Physical Therapy v. PTPN, Inc.* (2007) 148 Cal.App.4th 1130, 1136, review denied.)

- In an effort to attract new customers and retain existing members, Blue Shield expends significant "work and labor" essential to maintaining and improving its provider networks by sponsoring initiatives aimed at providing integrated, cost efficient health care, improving quality and efficiency to ensure that health care stays affordable for Blue Shield members, reducing costs and lowering rates, as well as developing and implementing integrated advanced technology systems for California that will allow doctors, hospitals and health plans to coordinate and improve health treatment outcomes. (*See generally* https://www.blueshieldca.com/bsca/about-blueshield/ newsroom/home.asp).

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

140. Blue Shield violated the CLRA by committing unfair and deceptive acts that directly undermined Plaintiffs' and Class Members' ability to access the provider network

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they were promised. Blue Shield's unfair and deceptive acts increased patients' costs when accessing provider networks and unilaterally reduced treatments and services available from those provider networks.

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

142. 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.

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

144. 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.

145. 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

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accomplishment of the wrongful conduct, wrongful goals, and wrongdoing.

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

147. Blue Shield'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 Shield 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 Shield 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 Shield.

SIXTH CAUSE OF ACTION

Breach of Contract

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

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

150. By misrepresenting provider networks, denying coverage for medical services on the basis that services were provided by an out-of-network provider that Blue Shield represented as in-network and failing to provide proof of insurance to consumers after accepting premium payments from them, Blue Shield and Does 1 through 100 have uniformly breached the terms and provisions of the individual health service plan contracts entered into with Plaintiffs and members of the Class.

151. As a direct and proximate result of Blue Shield's and Does 1 through 100's conduct and breach of contractual obligations, Plaintiffs and members of the Class suffered

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damages under the individual plan contracts in an amount to be determined according to proof at the time of trial.

SEVENTH CAUSE OF ACTION

Breach of the Implied Covenant of Good Faith and Fair Dealing

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

153. Blue Shield 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 misrepresenting provider networks covered under the individual health service plan contracts;

b. Unreasonably denying coverage for medical services on the basis that services were provided by an out-of-network provider that Blue Shield represented as in-network; and

c. Unreasonably failing to provide proof of insurance to consumers after accepting premium payments from them, effectively blocking access to physician and hospital services covered under the individual health plan contracts.

154. Plaintiffs are informed and believe and thereon allege that Blue Shield and Does 1 through 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.

155. 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 service plan contracts, plus interest, and other economic and consequential damages, in an amount to be proven at trial.

156. 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

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liable for those attorneys' fees, witness fees and litigation costs reasonably incurred in order for Plaintiffs to obtain their benefits under the health service plan contracts.

157. 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.

158. Defendants' conduct described herein was undertaken by Blue Shield'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 Shield. Blue Shield 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.

EIGHTH CAUSE OF ACTION

Declaratory Relief

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

160. 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 that "the court may make a binding declaration of these rights or duties,

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whether or not further relief is or could be claimed at the time."

161. An actual controversy has arisen between Plaintiffs and the members of the Class they represent, on the one hand, and Blue Shield 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 Shield's and Does 1 through 100's misrepresentation of provider networks, failure to provide proof of insurance to consumers while accepting premium payments, and Blue Shield's other misrepresentations and omissions as more fully described herein, as well as the operation of a telephone customer service call center where consumers are unable to obtain information due to long hold times and uninformed call center representatives, is prohibited by California law. Defendants contend that their conduct was proper.

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

PRAYER FOR RELIEF

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 Shield from continuing to engage in the conduct described herein;
3. An Order awarding Plaintiffs and the Class restitution and such other relief as the Court deems proper;
4. An Order awarding Plaintiffs 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;

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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 declaring the rights and obligations of Plaintiffs and Class members, on the one hand, and Blue Shield, on the other, with regard to the business practices alleged;
7. An Order awarding Plaintiffs' 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
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Plaintiffs demand a trial by jury on all issues so triable.
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DATED: September 23, 2014 Respectfully Submitted,
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SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
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By: ______________________
MICHAEL J. BIDART
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TRAVIS M. CORBY
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CONSUMER WATCHDOG
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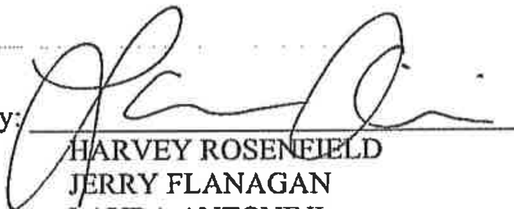
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13
By: ______________________
HARVEY ROSENFIELD
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JERRY FLANAGAN
LAURA ANTONINI
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LAW OFFICES OF SCOTT C. GLOVKSY, APC
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By: ______________________
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SCOTT C. GLOVKSY
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ARI DYBNIS
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Attorneys for Plaintiffs
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JURY DEMAND

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

DATED: September 23, 2014

Respectfully Submitted,

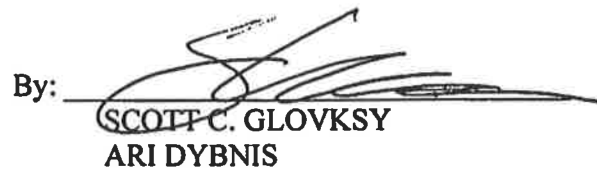
SHERNOFF BIDART ECHEVERRIA BENTLEY LLP

By: ______________________
MICHAEL J. BIDART
TRAVIS M. CORBY

CONSUMER WATCHDOG

By: ______________________
HARVEY ROSENFIELD
JERRY FLANAGAN
LAURA ANTONINI

LAW OFFICES OF SCOTT C. GLOVKSY, APC



By: ______________________
SCOTT C. GLOVKSY
ARI DYBNIS

Attorneys for Plaintiffs

AFFIDAVIT

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

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

3. As 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 Defendant Blue Shield 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 23rd day of September 2014, at Santa Monica, California.

LAURA ANTONINI

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
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