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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 **CLASS ACTION COMPLAINT** **Breach of Contract** **Breach of the Implied Covenant of Good Faith and Fair Dealing** **Declaration of Rights, Code Civ. Proc. § 1060** **Violations of the Consumer 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:

NATURE OF THE ACTION

1. Plaintiffs bring this action to challenge Blue Cross's "bait and switch" tactics of unilaterally and dramatically increasing "annual deductibles" and other "annual" and "yearly" out of pocket costs in the middle of the year on May 1, 2011. Consumers carefully consider premiums, annual deductibles, and other annual out of pocket costs when purchasing health insurance or deciding whether to renew an existing policy ("individual plan contract").

2. Indeed, the annual deductible is an essential term of the plan because it determines the amount a consumer must pay each year before an insurer will pay for health care expenses. For this reason, the amount of the annual deductible is often incorporated into the plan name. For example, Blue Cross's PPO Share 2500 plan includes an annual deductible of $2,500.

3. When a consumer purchases a plan with an annual deductible of $2,500, the consumer expects he or she will have to pay for the first $2,500 in health care services during the calendar year, and that the insurer will cover the remaining costs of health coverage according to the terms of the plan contract. Blue Cross's unilateral changes to the annual deductible at whim, however, have resulted in a moving target without any certainty of how much a consumer will have to pay to meet the deductible in any given calendar year.

4. 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 $525 million in dividends to shareholders in 2010.

c. Postponed similar mid-year changes to its nearly identical policies regulated by the California Department of Insurance ("CDI").

5. In addition to unilaterally raising the annual deductible and other out of pocket costs while escalating premiums, Blue Cross has made other unilateral changes to its individual plan contracts. For example, Blue Cross recently notified policyholders that it was reducing the policy term to just *one month*, which would purportedly allow Blue Cross to modify *any* "terms and conditions" of the individual plan contracts, including deductibles and other out of pocket costs, at each contract "renewal" on sixty days notice**—or up to six times per year**.

6. Through its conduct of unilaterally escalating annual out of pocket costs and unilaterally altering coverage descriptions ("Evidence of Coverage" or "EOC") to allow Blue Cross to change any benefit on just sixty days notice, Blue Cross has breached the individual plan contracts entered into with Plaintiffs and California consumers and breached the implied covenant

of good faith and fair dealing. Defendants' conduct also violates Health & Safety Code section 1360, which bars health care service plans [regulated by the Department of Managed Health Care] ("heath plans") from using any advertising or solicitation that is untrue or misleading, or any EOC that is deceptive. Blue Cross's and Does 1 though 100's misrepresentations about annual costs also violate Health and Safety Code section 1360, which prohibits health plans from misrepresenting the coverage they offer and its costs. Furthermore, the unilateral changes to the individual plan contracts violate provisions of the California Code of Regulations barring health plans from imposing restrictions or limitations that render contract benefits "illusory."

7. Blue Cross's conduct of representing and advertising that its plans have an "annual deductible" of one amount and then unilaterally increasing that amount during the annual period the deductible is accruing also violates the Consumer Legal Remedies Act ("CLRA"), California Civil Code section 1750, et. seq.

8. Moreover, the unilateral adoption by Blue Cross of EOC provisions which purport to allow Blue Cross to unilaterally change any plan contract term or condition and reduce the plan contract duration to just one month are unconscionable and thus violate the CLRA and Civil Code section 1670.5.

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

10. Plaintiffs bring this action on behalf of themselves and on behalf of a class of 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 and currently reside in California.

11. 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.

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THE PARTIES

12. Plaintiff Alison Heath is a resident of San Francisco, California. Ms. Heath is enrolled in an Anthem Blue Cross PPO Share $2,500 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 policy duration to just one month and allowing Blue Cross to change "any term and condition" of the plan contract on just sixty days notice. Attached as Exhibit "A" is a true and correct copy of Plaintiff Alison Heath's Evidence of Coverage, which is incorporated herein by reference.

13. Plaintiff Janet Kassouf is a resident of Hayward, California. Ms. Kassouf is enrolled in an Anthem 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 policy duration to just one month and allowing Blue Cross to change "any term and condition" of the plan contract on just sixty days notice. Attached as Exhibit "B" is a true and correct copy of Plaintiff Janet Kassouf's Evidence of Coverage, which is incorporated herein by reference.

14. Plaintiff David Jacobson is a resident of Santa Monica, California. Mr. Jacobson is enrolled in an Anthem Blue Cross PPO Share $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 policy duration to just one month and allowing Blue Cross to change "any term and condition" of the plan contract on just sixty days notice. Attached as Exhibit "C" is a true and correct copy of Plaintiff David Jacobson's Evidence of Coverage, which is incorporated herein by reference.

15. 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 insurance in this state.

16. 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.

17. 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

18. This Court has jurisdiction of 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 & Professions Code section 17200 et seq. and section Civil Code 1750 et. seq.

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

20. 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.

21. 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.

22. 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

23. Blue Cross and the individual plan contracts that are the subject of this class action are regulated by the Department of Managed Health Care ("DMHC") and subject to the requirements of Health & Safety Code sections 1340 through 1399.99 (the "Knox-Keene Act").

24. 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).)

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).)

25. 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 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 plan contract coverage benefits. (Health & Saf. Code § 1363(b)(1).) Health plans are specifically required by statute to list the plan "deductible" first in the coverage matrix. (Health & Saf. Code § 1363(b)(1)(A).)

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

27. 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

28. Blue Cross and Does 1 through 100 often represent, market, and advertise individual plan contracts as having "annual" or "calendar year" deductibles. Attached as Exhibit "D" is a true and correct copy of a Blue Cross marketing brochure listing the "calendar year" deductibles of various individual coverage options, including the PPO Share plans in which

Plaintiffs Alison Heath, Janet Kassouf and David Jacobson are enrolled.

29. In a health insurance policy, the deductible is the amount of expenses that the insured must pay out of pocket before an insurer will pay any expenses. Generally, the higher the deductible, the lower the premium and vice versa.

30. Plaintiffs Alison Heath, Janet Kassouf, and David Jacobson are currently enrolled in Blue Cross PPO Share $2,500, $1,500, and $500 individual plan contracts ("the Plans") respectively. The dollar value in the plan name indicates the amount of the annual deductible. Plaintiffs have each been enrolled in their respective plans for more than ten years.

31. 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, Heath, Kassouf, and Jacobson are responsible for an annual deductible of $2,500, $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."

32. 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 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.

33. 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 coverage scope of the Plans in several ways effective May 1, 2011, namely by increasing the annual deductible from $2,500 to $2,950, $1,500 to $1,750, and

$500 to $550 respectively.

34. 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 Heath, $6,000 to $7,050 for Kassouf, and $5,000 to $5,850 for Jacobson. Additionally, the "annual" prescription drug deductible would increase from $500 to $575 for Heath, and $250 to $275 for Kassouf and Jacobson. Attached as Exhibit "E" is a true and correct copy of the February 2011 Letter.

35. Blue Cross and Does 1 through 100 announced similar unilateral mid-year changes to the annual out of pocket costs imposed on Members for other Blue Cross individual plan contracts. According to the February 2011 Letter, annual deductibles for the PPO Share 1000 plan would increase to $1,150, PPO Share 3500 plan to $4,100, PPO Share 3500-R plan to $4,100, PPO Share 5000 plan to $5,900, and the PPO Share 7500 plan to $8,850. In addition, the February 2011 Letter announced increased premiums, increased annual copayment/coinsurance maximums, and increased annual prescription drug deductibles.

36. On March 21, 2011, the CDI, which regulates Blue Cross Life and Heath insurance policies, announced that the company would delay deductible and copay increases until January 1, 2012 and premium increases until July 1, 2011.[1] 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 policies it would not delay increases to annual deductibles and other benefit changes for its DMHC-regulated plans.[2] On May 1, 2011 Blue Cross implemented the mid-year policy changes on its DMHC-regulated plans.

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[1] 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.

[2] 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.

37. 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.

38. Around the same time that it implemented these mid-year changes to annual deductibles and other annual out of pocket costs, in an "Endorsement to the Individual PPO Share" plan contracts mailed to consumers in or about May 2011 and effective August 1, 2011 ("August 2011 Endorsement"), Defendants sought to unilaterally convert individual plan contracts to one month in duration. The effect of the August 2011 Endorsement is to purportedly allow Blue Cross to increase "annual" deductibles and other out of pocket costs and to "modify or otherwise change the terms and conditions" of the plan "including, without limitation, subscription charges, covered benefits, Deductibles, copayments or coinsurance" every two months – up to six times each year. ("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 terms, the individual plan contracts purportedly terminate at the end of each month and "renew" upon payment of the next month's premium. The Endorsement provides that Blue Cross may make changes to the plan at each "renewal." Attached as Exhibit "F" is a true and correct copy of the August 2011 Endorsement.

CLASS ALLEGATIONS

39. 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 persons who are currently enrolled or who were enrolled in a Blue Cross individual plan contract whose calendar-year deductible and other annual out of pocket costs were unilaterally increased mid-year and/or whose policies were reduced to one month in duration.

40. 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.

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

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

43. 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.

44. 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.

45. 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.

46. 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.

47. 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.

48. 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.

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

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FIRST CAUSE OF ACTION

Breach of Contract

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

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

52. By changing "annual" deductible and other "annual" and "yearly" out of pocket costs in the middle of the year, as well as unilaterally converting individual plan contracts to one month in duration and unilaterally amending the individual plan contracts to allow Blue Cross to change the terms and conditions of the plans during the year on sixty days notice, Blue Cross and Does 1 though 100 have breached the terms and provisions of the individual plan contracts entered into with Plaintiffs and members of the Class.

53. 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

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

55. 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" 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 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' insurance coverage claims as a result of Blue Cross's

unreasonable reductions in coverage.

d. Unreasonably and unilaterally converting individual plan contracts to one month in duration and unilaterally amending the individual plan contracts to allow Blue Cross to change the terms and conditions of individual plan contracts during the year on sixty days notice.

56. 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.

57. 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.

58. 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.

59. 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.

60. 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.

THIRD CAUSE OF ACTION

Declaratory Relief

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

62. 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."

63. 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 plan contracts between them. Specifically, Plaintiffs and the Class contend that Blue Cross's and Does 1 through 100's unilateral increases to "annual" deductibles and other "annual" out of pocket costs in the middle of the year, as well as Blue Cross's unilateral conversion of individual plan contracts to one month in duration and unilateral amendments to individual plan contracts purporting to allow Blue Cross to change the terms and conditions of the individual plan contracts during the year 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.

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

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FOURTH CAUSE OF ACTION

Violation Civil Code § 1750, et seq. –

Consumer Legal Remedies Act

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

66. Defendants have violated the CLRA, Civil Code section 1770, subdivisions (a)(9), (a)(14), and (a)(19) by:

a. Unilaterally adopting unconscionable and unenforceable terms in individual plan contracts. Since the terms are both procedurally and substantively unconscionable, they are unenforceable as a matter of law. The individual plan contract EOCs and the August 2011 Endorsement are procedurally and substantively unconscionable because:

i. The EOCs 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 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 August 2011 Endorsement render the individual plan contracts illusory because Blue Cross now may alter the individual plan contract terms to avoid paying for any health care services.

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 a transaction confers or involves rights, remedies, or obligations which it does not have.

d. Advertising goods or services with the intent not to sell them as advertised.

67. Plaintiffs and the Class members have suffered harm as a result of these violations.

68. Plaintiffs have suffered as a result of Defendants' unlawful conduct because they purchased individual plan contracts, or renewed individual plan contracts, believing, inter alia, that "annual" deductible and other "annual" out of pocket costs and plan benefits would remain unchanged throughout the year and are now subject to increased yearly costs and other limitations.

69. Plaintiffs have also suffered as a result of being subject to the unconscionable provisions allowing Defendants to alter "annual" contract benefits up to six times each year and reducing the contract term to just one month in duration. Defendants misrepresented and concealed from Plaintiffs that Defendants do not have the right to enforce these contract terms.

70. 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.

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

72. Such wrongful actions and conduct are ongoing and continuing. Unless Defendants are enjoined from continuing to engage in such wrongful actions and conduct, members of the consuming public will continue to be damaged by Defendants' conduct.

73. 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.

74. Plaintiffs and the Class are entitled to an injunction, pursuant to Civil Code section 1780, subdivision (a)-(b), prohibiting Defendants from continuing to engage in the above-described violations of the CLRA and any other relief the Court deems proper.

FIFTH CAUSE OF ACTION

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

Unlawful Business Acts and Practices

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

76. 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…."

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

78. 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.

79. In relevant part, section 1360 bars a health care service plan 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."

80. 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 other benefits.

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

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

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81. In addition, 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 28 CCR section 1300.67.4, subdivision (a)(3)(A).

82. 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."

83. 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 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 to meet the deductible in any given calendar year, thus rendering the plan contracts illusory.

84. 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 other terms and conditions of the individual plan contracts every two months. Specifically, under the terms of the August 2011 Endorsement, 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 any "renewal" date following sixty days notice—hence, the Endorsement purports to allow Blue Cross to change any terms and conditions of the individual plan contracts six times per year. With the unilateral changes to the plan contracts, Defendants have provided themselves the ability to ensure that consumers must pay otherwise covered health care costs out of pocket, thus rendering the plan contracts illusory and "transferring the financial risk of health care" from Blue Cross to consumers in contravention of the intent of the Knox-Keene Act.

85. 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.

86. 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 under their health plan contracts and/or paying a higher annual deductibles and other annual out of pocket costs than set forth in the Plan EOCs.

87. 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 decreased benefits and disgorgement of the profits derived from Blue Cross's unlawful business acts and practices.

88. 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

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

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

91. 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.

92. 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.

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

94. 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.

95. 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.

96. 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

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

98. 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.

99. As more fully described herein, Defendants' misleading and fraudulent statements in EOCs, the February 2011 letter, the August 2011 Endorsement, 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 enrollment in plan contracts. Such acts are fraudulent business acts and practices.

100. 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.

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

102. 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.

103. 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:

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., 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: November 14, 2011

Respectfully Submitted,
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Todd M. Foreman
Jerry Flanagan
CONSUMER WATCHDOG

By: _____
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