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Superior Court of California
County of Los Angeles
JUN 13 2017
Sherri R. Carter, Executive Officer/Clerk
By _____, Deputy
Judi Lara

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

BRAD HEINZ, an individual; and on behalf of a class of others similarly situated,

Plaintiffs,

vs.

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM; BOARD OF ADMINISTRATION OF CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM (collectively "CalPERS");

ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY, a California corporation; DOES 1-100,

Defendants.

Case No.:

BC664844

CLASS ACTION

COMPLAINT FOR:

(1) BREACH OF CONTRACT;
(2) BREACH OF FIDUCIARY DUTIES;
(3) MISREPRESENTATION;
(4) BREACH OF IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING;
(5) UNFAIR BUSINESS PRACTICES,
(6) UNJUST ENRICHMENT
(7) EQUITABLE RELIEF
(8) VIOLATION OF STATUTORY DUTIES;
(9) OTHER RELIEF, INCLUDING ATTORNEYS' FEES

DEMAND FOR JURY TRIAL

EXHIBITS 1 THROUGH 61

RECEIPT #: CCH520872033
DATE PAID: 06/13/17 10:36 AM
PAYMENT: $1,435.00 310
RECEIVED:
CHECK: $1,435.00
CASH: $0.00
CHANGE: $0.00
CARD: $0.00

CIT/CASE: BC664844
LEA/DEF#:

Part 1 of 4

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

BRAD HEINZ, an individual; and on behalf of a class of others similarly situated, Plaintiffs, vs. CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM; BOARD OF ADMINISTRATION OF CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM (collectively "CalPERS"); ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY, a California corporation; DOES 1-100, Defendants.	Case No.: **CLASS ACTION** **COMPLAINT FOR:** **(1) BREACH OF CONTRACT;** **(2) BREACH OF FIDUCIARY DUTIES;** **(3) MISREPRESENTATION;** **(4) BREACH OF IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING;** **(5) UNFAIR BUSINESS PRACTICES;** **(6) UNJUST ENRICHMENT;** **(7) EQUITABLE RELIEF;** **(8) VIOLATION OF STATUTORY DUTIES;** **(9) OTHER RELIEF, INCLUDING ATTORNEYS' FEES.** DEMAND FOR JURY TRIAL EXHIBITS 1 THROUGH 61

The above named Plaintiff, on his own behalf and on behalf of all other similarly situated individuals, alleges as follows:

1. Plaintiffs are a class of people who were enrolled in Preferred Provider

Organization ("PPO") health insurance offered and/or administered by the California Public Employees' Retirement System and its Board of Administration (collectively "CalPERS") and Anthem Blue Cross Life & Health Insurance Company ("Anthem" or "Anthem Blue Cross").

2. Between 2006 and 2014, CalPERS and/or Anthem engaged in a common policy or practice of improperly and artificially reducing the "Allowable Amount" for "out-of-network" non-emergency medical services.[1]

3. By artificially reducing the "Allowable Amount," CalPERS and/or Anthem caused reimbursements for "out-of-network" medical expenses to be substantially below prevailing standards, including below the "usual, customary, and reasonable" (UCR) standards.[2]

4. Plaintiffs and the class presented their claims and received reimbursement from Anthem and/or CalPERS for "out-of-network" non-emergency medical expenses, but Anthem and/or CalPERS reimbursed each person less than required under contract, industry standard, statute, or law.

5. In addition, CalPERS and/or Anthem hid the improper policy and practice of artificially reducing the "Allowable Amounts" for "out-of-network" non-emergency expenses and the resulting reduced reimbursements, which was only recently discovered.

6. CalPERS' statutory obligations when offering health benefits are governed in part by the Public Employees' Medical and Hospital Care Act ("PEMHCA"), *Government Code* §§22750 to 22944.3, and regulations based thereon. The regulations require that the payment schedule must be sufficient to meet the "major share of usual, customary, or reasonable charges for such services" and "shall take into account the Relative Value Studies of the California Medical Association." (2 *CCR*, § 599.510).

7. However, the California Medical Association has not produced any Relative Value Studies since the 1980's.

8. CalPERS and Anthem do not harmonize the law, all of the contract terms, or

[1] CalPERS' and/or Anthem's practice of short-changing these policyholders is similar to the systematic under-reimbursement of "out-of-network" medical expenses challenged in other cases (see, e.g., the *Ingenix, et al* litigation).

[2] CalPERS' and/or Anthem's reimbursement were also substantially below industry standard that use Medicare as a baseline. **Exhibit 61.**

prevailing standards. Instead, CalPERS and Anthem argue that one part of 28 CCR §1300.711(a)(3) holds that the terms in the enrollees' Evidence of Coverage (EOC) control the terms of reimbursement. Then CalPERS and Anthem focus solely on one term in the EOC: the third subpart of the "Allowable Amount" definition. CalPERS and Anthem ignore the other terms and examples in the EOC, including those that represent that CalPERS and Anthem will provide identical "Allowable Amounts" calculations for "in-network" and "out-of-network" services. CalPERS and Anthem say that the third subpart of the "Allowable Amount" definition allows Anthem complete discretion to determine an "Allowable Amount" as Anthem finds "appropriate," without reference to any standards, including without requiring "usual, customary, and reasonable" rates (UCR). CalPERS and Anthem then cite to dicta in *Orthopedic Specialists of Southern California v. California Public Employees' Retirement System* (2014) 228 Cal.App.4th 644 (a *quantum meruit* case) that the "terms" in the EOC control even if the terms are not fair.

9. In their "logic," CalPERS and Anthem view incomplete partial terms in isolation, take irrelevant case law out of context, and apply the irrelevant case law to the isolated incomplete facts. As a result, CalPERS and/or Anthem purport to allow Anthem the unfettered discretion to calculate the "Allowable Amount" at whatever low rate Anthem chooses, and then reimburse "out of network" medical services as a set percentage of this arbitrarily reduced, low "Allowable Amount."

10. Among other things, CalPERS, and Anthem's logic is contrary to law and unsupported by fact. CalPERS and Anthem's reliance on *Orthopedics Specialists* is misplaced. This is not a *quantum meruit* case. Plaintiffs allege breaches of statutory rights, fiduciary duties, and contract law based in part on non-negotiable written form contracts offered by CalPERS which is a fiduciary. Factually, CalPERS and Anthem fail to consider the other terms and express examples in the EOC. The EOC's other terms and express examples contradict CalPERS' and Anthem's isolated "facts." Indeed, the EOC's express examples indicate that the "Allowable Amounts" will be calculated in an identical manner for "in network" or "out-of-network" services. The other terms in the first two subparts of the "Allowable Amount" definition require

reimbursement based on contracted rates or the UCR rates. CalPERS and/or Anthem suggest that the third subpart is wholly different than and overrides the express examples and the first two subparts, but there is no notice of this. The third subpart is also so vague, inconsistent, and without standards as to be undefined or illusory. Among other things, CalPERS and Anthem also ignore that (i) 28 CCR §300.71 provides standards when the EOC is unclear; and (ii) 2 CCR §510.598 requires CalPERS to reimburse class members for at least the majority share of the usual, customary, and reasonable rates.

11. Common factual issues predominate, including: (1) What are appropriate benchmarks or bases for determining the "Allowable Amount" and reimbursement for "out-of-network" non-emergency medical services under the PPO coverage? (2) Did CalPERS and Anthem use appropriate benchmarks or other industry standards for calculating "Allowable Amounts" and reimbursement for out-of-network non-emergency medical services in the PPO coverages?

12. Common legal and contract interpretation issues predominate, including:

a) Do the Knox Keene Act statutes in *Health and Safety Code* §§1340 *et seq* and regulations 28 CCR § 1300.71 *et seq.* apply in whole or in part?[3]

(b) Should the totality of the language, examples, and terms in the EOC be considered?

(c) Does the language and placement of the third subpart of the "Allowable Amount" definition in the Evidence of Coverage (EOC) allow Anthem and/or CalPERS unfettered discretion to calculate the "Allowable Amount" for purposes of reimbursement at rates substantially below (i) the contracted rate; (ii) the "usual, customary, and reasonable" (UCR) rate, and (iii) other prevailing standards?

(d) Did CalPERS violate its fiduciary duties, including by the reduced "Allowable Amount," unreasonably low reimbursement, inadequate oversight of Anthem,

[3] In *Orthopedic Specialists*, the court applied the Knox Keene Act and 28 CCR 1300.71 but CalPERS argues that Knox Keene Act did not apply.

inadequate disclosure, or other acts or omissions? For example, although CalPERS could provide Anthem additional "compensation based on carrier performance" under *Government Code* §22864(b)(1), did any "performance-based compensation" paid to Anthem breach CalPERS' duty of loyalty to class members that contracted for PPO health insurance coverage by compensating Anthem for reducing the reimbursement to those class members?

(e) Did CalPERS and/or Anthem breach the PPO contract(s) by the greatly reduced "Allowable Amount," unreasonably low reimbursement, inadequate disclosure, or other acts or omissions?

(f) Did CalPERS and/or Anthem misrepresent, undertake unfair business practices, unjustly enrich themselves, or by act or omission violate Plaintiffs' legal rights raised herein?

13. Named Plaintiff and proposed class representative, Brad Heinz, suffered increased costs and damages by CalPERS' and Anthem's acts or omissions improperly reducing the "Allowable Amounts" in PPO coverage and inappropriately reducing reimbursements for "out-of-network" non-emergency medical expenses over the period of 2008 to 2014.[4]

14. As an illustration, Heinz enrolled in PPO health insurance from CalPERS/Anthem from 2006 to 2014. CalPERS and Anthem distributed standardized promotional material, form contracts, and Evidence of Coverage documents that indicated that the "Allowable Amount" would be calculated in an identical method and amount whether the services were "in plan" or "out of plan." **Exhibits 24-26, 28, 41-53, 55, 59, and 60.**

15. Over this time of 2006 to 2014, Heinz saw a therapist for counseling. Initially, the doctor was "in network" and contracted with Anthem at an agreed rate of $299.57 per session. **Exhibit 14, page 2.** The services were coded as 90807 and 90837 and labelled "cognitive services." **Exhibits 3-23, 27, 29-32, 34, 36, 38, 54.** In May 2008, the doctor went "out-of-network" and stopped contracting with Anthem, but still saw Heinz in the same location

[4] It is understood that CalPERS and/or Anthem calculated the "Allowable Amount" for "out of network" emergency care at UCR rates; however, if they did not, then those who sought reimbursement for "out of network" emergency services are also in the class.

providing the same services. **Exhibit 14, page 2 and Exhibit 23.** When the doctor went out of plan, CalPERS and/or Anthem reduced the "Allowable Amount" to between $76.91 and $136.86 per session for the same services. **Exhibit 24.** Then CalPERS and Anthem reduced the reimbursement to 60% of the "Allowable Amount," reimbursing Heinz between $46.15 and $82.12 per session. **Exhibits 3-23, 27, 29-32, 34, 36, 38, 54.**

16. Arising out of prior litigation about unfair reimbursement rates, FairHealth.org[5] and other similar databases were set up by court order to provide comparison data on appropriate out-of-network reimbursement rates, including for services according to standardized medical codes and by zip code. See infra at paragraphs 128 to 135. For example, Heinz's claims were numerically coded as 90836 and 90837[6] and labelled as "cognitive services" in San Francisco. **Exhibits 3-23, 27, 29-32, 34, 36, 38, 54.** Under FairHealth.org, the estimated UCR charge for cognitive services (90837) in San Francisco was two hundred dollars ($200.00) per 45 to 55 minute session. Under FairHealth.org, the Medicare baseline reimbursement for cognitive service (90837) in San Francisco was two hundred dollars ($200.00) per session. **Exhibit 61.**

17. By its inappropriate policies and practices of greatly reducing the "Allowable Amounts," Anthem and/or CalPERS greatly reduced the total money that it paid out in reimbursements to Heinz and the class. As a representative example of the inappropriate policies and practices of greatly reducing the "Allowable Amount" below industry standards, CalPERS and/or Anthem reimbursed Heinz $45.15 to $82.12 per session when CalPERS and/or Anthem should have reimbursed him at a rate of $120.00[7] or higher per session.

18. Factually, all of the claims of each class member have been presented, accepted, and already paid by CalPERS and/or Anthem, albeit at a greatly reduced rate.

19. After exhausting the separate required Anthem and CalPERS administrative processes individually and on behalf of the proposed class, Brad Heinz asserts individual and representative claims on behalf of all CalPERS members, beneficiaries, and others who were

[5] For a brief history how the FairHealth.org database emanated from the Attorney General's resolution of the *Ingenix* under-reimbursement litigation, see infra at p 31-32 and **Exhibit 58.**

[7] A $120.00 reimbursement is the $200 "Allowable Amount" multiplied by the PPO rate of 60%.

enrolled in PPO insurance from CalPERS/Anthem for any of the periods between and including 2006 to 2014 who did not receive proper reimbursement and/or where CalPERS and/or Anthem breached statutory rights, fiduciary duties, the contract, or other rights.

20. Heinz and the class seek the appropriate contracted percentage of the UCR reimbursement rates for their "out-of-network" medical expenses (including medical services, fees, costs, charges, tests, labs, procedures, equipment, treatments, surgery, exams, and other accepted expenditures).

21. About 365,000 "total members" were enrolled in CalPERS' and Anthem's PPO insurance *each year* in the period between 2006 and 2014. **Exhibit 60, page 7.** More than twenty-five percent of CalPERS members enroll in PPO coverage. **Id.** The principal incentive to buy PPO insurance (PersCare, PersChoice, PERSSelect,[8] *et al.*) is to be reimbursed for "out-of-network" service providers. The number of "out-of-network" claims per member per year is currently unknown to Plaintiff. The dollar value of each claim is significant, as indicated herein.

22. The class members are all similarly situated, factually and legally. CalPERS and/or Anthem failed to contract, establish, administer, and set up the PPO reimbursement process so that reimbursement was at UCR rates or at the majority share of UCR rates. Each year, CalPERS offered three PPO plans that were specifically targeted at individuals who wanted to seek medical care from "out-of-network" providers.[9] CalPERS and Anthem promoted, contracted, and administered the PPO coverage via standardized nonnegotiable form contracts, publications, and processes. CalPERS' and/or Anthem's standardized materials omitted, failed to disclose, and distorted how the "Allowable Amount" would be calculated for non-emergency, "out-of-network" medical expenses. Anthem administered all of the claims for the PPO plan for CalPERS for the period of 2006 to 2014. Each claim by each class member has been made and presented to CalPERS and/or Anthem and accepted. Heinz and the class performed all aspects of

[8] "PERS Select, introduced in 2008, has a smaller network of medical groups, but offers a significantly lower premium than PERS Choice or PERSCare. PERS Select is a lower cost option for members who value the freedom of choice offered through a PPO plan design." **Exhibit 55.**

[9] CalPERS also required that contracting agencies not offer other health insurance options if the employer contracted to offer the CalPERS health insurance. See *Government Code* §22934.

their contractual and other requirements. Each claim by each class member has been paid by CalPERS and Anthem, albeit reimbursed at an unreasonably low, unfair, or unconscionable rate.

23. Reliable electronic data and business records are readily available. CalPERS and Anthem have all of the information, including about the cost, actual claim payments, and contract allowance amounts in their databases. See *Government Code* §22854.5. Reliable electronic data exists in Anthem's and CalPERS' information technology systems to ascertain the class members, the "out-of-network" claims already paid, the reimbursement rates paid, and then to compare those rates, claims, and services (in the specific locale) with the UCR[10] or appropriate reimbursement rates that are readily available in the comparable database[11] such as FairHealth.org or similar databases. **See Exhibit 61**; *www.fairhealth.org/Toolsforconsumers*. However, CalPERS and Anthem indicate that their data, methodology, practices, and policies related to calculating the "Allowable Amount" and reimbursements are confidential and deemed a "trade secret" exempt from disclosure. *Government Code* §22854.5.

24. In addition, the data and comparison are readily made without requiring review of individual files as the claims are coded in standardized numerical values and forms that allow reliable comparison between CalPERS/Anthem reimbursement rates and rates in the FairHealth.org or other databases, including by medical code, location, and service.

25. The data can (i) determine Plaintiffs' damages; (ii) determine CalPERS' and Anthem's liability for its unreasonably low reimbursement rates; and (3) allow Anthem and CalPERS to assert defenses in a readily manageable way without requiring review of individual files or re-determination of claims.

26. CalPERS owes Heinz and all members of the putative class (collectively "Plaintiffs") mandatory fiduciary duties pursuant to the California *Constitution*, statute, case law, and enactments. (See *Hittle v. Santa Barbara Cnty. Employees Ret. Assn.* (1985) 39 Cal.3d 374, *O'Neal v. Stanislaus County Retirement System* (2017) 8 Cal.App.5th 1184.) CalPERS breaches

[10] It appears that CalPERS and Anthem may have used "usual, customary, and reasonable" (UCR) or similar higher reimbursement rates for "out of network" emergency services, but do not use the UCR or higher reimbursement for "non-emergency" services, so it is likely that Anthem itself has a data base of usual, customary and reasonable reimbursement rates.

[11] See 2 CCR 599.510(a).

its fiduciary duties of loyalty, good faith and fair dealing, to account, and other duties enumerated below. For example, CalPERS breached its fiduciary duties including when it has failed to act in the interest of Plaintiffs, failed to fully disclose, acted adversely, failed to account, and sought advantage for CalPERS, Anthem, or others, including but not limited to offering or providing compensation to Anthem based on carrier performance that rewards Anthem for reducing reimbursement to its members, by failing to reimburse medical expenses at a reasonable rate, and failing to reasonably apply the "Allowable Amount" term in the EOC. CalPERS also failed to oversee Anthem sufficiently. CalPERS has various mandatory nondiscretionary fiduciary duties, one of which is a duty to correct all errors of the system, including under *Government Code* §§20160 and 20164.

27. Heinz also asserts that Anthem and CalPERS, separately, severally, or jointly, (1) breached their contractual duties, (2) misrepresented in a manner that perpetrated a fraud on plan participants, (3) omitted material terms, (4) failed to adequately disclose, including that they were offering a nonstandard PPO plan that produced a greatly reduced "Allowable Amount" for non-emergency "out-of-network" medical expenses; (5) failed to act consistent with their legal, fiduciary, and other duties and obligations under law and statute, (6) failed to act in good faith and deal fairly, and (7) otherwise acted unlawfully or incorrectly as described herein.

28. Heinz individually and as a representative of a proposed class of those similarly situated also asserts claims against CalPERS and/or Anthem, individually, severally, or jointly, for (1) breach of contract, (2) misrepresentation, (3) breach of the implied covenant of good faith and fair dealing, (4) unlawful, unfair and fraudulent business practices, (5) conversion, (6) unjust enrichment, (7) accounting, (8) breach of their various fiduciary duties, and (9) breaches of their various other duties.

JURISDICTION AND VENUE

29. **Jurisdiction**. Jurisdiction is proper in the Superior Court of Los Angeles County. (*Code of Civil Procedure,* §410.10.) The amount in question is greater than $25,000. This Court has personal jurisdiction over CalPERS as a California state agency headquartered in California. A substantial amount of the wrongdoing alleged in this Complaint occurred and will occur in Los

Angeles County. CalPERS also maintains a regional office in Glendale, CA, specifically to serve Los Angeles County, including in matters related to the PPO coverage as alleged in this Complaint. Anthem also maintains offices or representatives in Los Angeles County.

30. **Venue**. Venue is proper in the County of Los Angeles, including as it is the county where the obligation to reimburse is to be performed. (*Code of Civil Procedure*, §395(a).)

PARTIES

31. **CalPERS**. CalPERS is a constitutional trust and a public retirement association authorized by Article XVI, Section 17, of the California *Constitution*. Authority over CalPERS' operations, formulation of its policy and practice, and approval and ratification of its actions vests in the Board of Administration of CalPERS. CalPERS and its Board owe fiduciary duties to Plaintiffs regarding the health insurance plans pursuant to case law, statute, and Article XVI, Section 17, of the California *Constitution*. (*O'Neal, supra*; *Hittle, supra*, at 389-90.) CalPERS and its Board of Administration are collectively referred to herein as "CalPERS."

32. CalPERS is responsible for selecting, administering, overseeing, and managing the health insurance offerings and reimbursements. CalPERS and Anthem are responsible for creating the publications, communications, and contracts used to promote or transact PPO insurance. CalPERS operates, oversees, and is responsible for its health insurance plans, including the PERSCare, PERSChoice, PERSSelect, and other PPO health plans, even though they are administered through contracts with third party administrators, including Anthem Blue Cross. (*Mintz v. Blue Cross of California* (2009) 172 Cal.App.4th 1594, 1598–1599.)

33. CalPERS is a separate and distinct legal entity from the State of California. CalPERS is a unit of the Government Operations Agency. *(Gov. Code,* §20002.)

34. **Anthem Blue Cross**. Anthem Blue Cross contracts with CalPERS to administer the PPO coverage and reimbursement process. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.

35. **Employers Are Not Necessary Parties.** The employers, contracting agencies and state agencies that have employed or will employ Plaintiffs or members of the proposed class are

not necessary parties since PPO insurance is provided and administered by CalPERS.

36. **Plaintiffs**. Plaintiffs are a proposed class of CalPERS member and beneficiaries who were enrolled in CalPERS/Anthem PPO insurance and received unreasonably low, unfair, or unconscionable reimbursement. The proposed class is described in more detail *infra* at paragraphs 199 -204, pages 42-43.

STATEMENT OF FACTS

I. Background

37. In standardized publications and on its website, CalPERS offered a choice of differing health plans, including three PPO options (PERSCare, PERSChoice, PERSSelect, etc.) and managed care options. **Exhibits 24-27, 28, 41-53, 55.** CalPERS' and Anthem's standardized promotional material present the PPO coverage as consistent with industry standards for reasonable reimbursement for "out-of-network" medical expenses. **Id.** CalPERS and Anthem used standardized non-negotiable form contracts to promote and to transact the PPO insurance coverage. **Exhibits 39-40**. Each purchaser signed a standardized enrollment form to get PPO coverage. **Exhibits 39-40**.

38. After contracting for PPO coverage by standardized forms, another standardized form contract arises—the evidence of coverage (EOC)— between CalPERS and each proposed class member.[12] CalPERS and Anthem do not regularly distribute the EOC to each purchaser. The EOC is available upon request. Contractually, the EOC governs a health plan's obligations to its members and their dependents. (See *Watanabe v. California Physicians' Service* (2008) 169 Cal.App.4th 56, 67.)[13] Payment for nonemergency services provided by "out-of-network"

[12] The proposed class members are likely also third party beneficiaries of the contract between CalPERS and Anthem Blue Cross.

[13] If the Department of Managed Care or Department of Insurance (DOI) has jurisdiction or authority over CalPERS and Anthem, then the EOC's contents are specifically regulated. (*Cal. Code Regs.*, tit. 28, §1300.63.1.) Even if these departments do not have authority, their regulations are relevant to determining custom and reasonableness in state insurance contracts, including PersCare, PERSChoice, and the PERSSelect plans.

providers is governed by the EOC. (*Cal. Code Regs.*, tit. 28, § 1300.71(a)(3)(C) [14] For example, the three subpart definition of "Allowable Amount" and the examples in EOC indicate that the "Allowable Amount" would be the same or similar whether one used a PPO doctor or a non-PPO doctor. The EOCs are attached as **Exhibits** 24-26, 28, 41-45.

II. Statement of Facts

39. From January 1, 2006 through December 31, 2008, Heinz was enrolled in the "PERSCare PPO" plan. **Exhibits 27, 39-40.**

40. From January 1, 2009 through December 31, 2014, Heinz was enrolled in the "PERSChoice PPO" plan. **Exhibits 27, 29-32, 34, 36, 38-40.**

41. Both PERSCare and PERSChoice are CalPERS PPO plans administered by Anthem. **Exhibits 27, 29-32, 34, 36, 38-40.**

42. Heinz has seen a medical doctor, Joe A. Walker, M.D. ("Dr. Walker"), for non-emergency medical services in San Francisco on a regular basis from at least 2006 to 2015. **Exhibits 27, 29-32, 34, 36, 38.**

43. Before May 2008, Dr. Walker was a member of the Physicians Foundation Medical Group ("Physicians Foundation") under contract with Anthem as a Preferred Provider ("PP"). **Exhibits 14, 23.** As of April 2008, Dr. Walker billed $420 for a 50-minute visit, his standard billing rate for such services. Anthem approved a "contract" payment rate to Dr. Walker of $299.97 per visit. **Exhibits 14, 23, 54.**

44. In other words, when in-network, Anthem and CalPERS calculated a contract rate or "Allowable Amount" for Dr. Walker at $299.97 per visit. Anthem specifically recognized this: "The member has seen this same Doctor under a different PPO Tax ID # & the Contracted rate was $299.57." **Exhibit 14, page 3.**

45. Pursuant to Heinz's Anthem contract, Anthem paid 80% of the contract rate or "Allowable Amount" (80% of $299.97 is approximately $239.65), and then Heinz was billed for and paid the remaining 20% (approximately $60). **Exhibit 27**

[14] "For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage." *Cal. Code Regs.*, tit. 28, § 1300.71(a)(3)(C).

46. CalPERS' and Anthem's hidden policy and practice of providing unreasonably low reimbursement rates or "Allowable Amounts" for "out-of-network" medical expenses was only discovered by chance in that Dr. Walker went from "in-network" to "out-of-network" in May 2008. During this whole period of 2006 to 2014, Dr. Walker provided the same services to Mr. Heinz in the same location, i.e. both before and after going "out-of-network". **Exhibits 27, 29-32, 34, 36, 38, 54.**

47. Specifically, beginning in or about May 2008, Dr. Walker terminated his relationship with Physicians' Foundation, thus choosing to no longer be a contracting Preferred Provider ("PP") physician with the Anthem plans. Instead, he was deemed a Non-Preferred Provider ("NPP") physician (i.e. "out-of-network"). Dr. Walker continued his "Billed Rate" at $420 per visit just as he had done while a PP. Dr. Walker agreed to continue to provide medical services to Heinz as an NPP physician, but insisted on a minimum payment of $250 per visit. Dr. Walker required Mr. Heinz to pay the $250 fee for each session on a monthly basis and then Mr. Heinz would seek reimbursement by submitting the claims to Anthem. Later, Dr. Walker increased this minimum fee to $275 per visit. **Exhibits 14, 23, 54.**

48. Monthly, Heinz paid Dr. Walker as an NPP (i.e. "out-of-network") provider the full minimum payment ($250 per visit, and later $275 per visit) and then timely sought reimbursement from Anthem. **Exhibits 27, 29-32, 34, 36, 38, 54.**

49. Pursuant to the express terms of the PPO coverage, Heinz understood that he would be paying a higher percentage of the "Allowable Amount" (increasing from 20% to 40%), and Anthem would be paying a lower percentage (decreasing from 80% to 60%) of the "Allowable Amount" because Dr. Walker was now "out-of-network." **Exhibits 3-23.** Specifically, Heinz expected that Anthem would only pay 60% of the "Allowable Amount," and Heinz would be responsible for paying the remaining 40% of the "Allowable Amount," because Dr. Walker was now an NPP.

50. Heinz also expected that Anthem would not substantially change the calculation of the "Allowable Amount" for Dr. Walker's services. **Exhibit 3-23, 54.** The services had not changed. **Exhibits 27, 29-32, 34, 36, 38, 54.** Heinz expected that Anthem would calculate the

"Allowable Amount" at or near (1) the prior "contract rate" or (2) the usual, customary, or reasonable rate for similar medical services in the community (which both should be substantially the same amount because Anthem could only agree to contract with Dr. Walker at or near a UCR rate[15], including because a higher rate would be an unlawful gift of CalPERS' "public trust funds"). **Exhibit 3-23, 54.** Dr. Walker continued to bill at the rate of $420 per visit just as he had done while a PP.

51. Heinz timely and appropriately presented the claims to Anthem, which accepted the medical expenses under the PPO coverage. **Exhibits 27, 29-32, 34, 36, 38.**

52. The dispute is about the appropriate "Allowable Amount" and the amount of reimbursement. (The validity of the claims is not at issue. CalPERS and Anthem accepted and paid the claims).

53. After Dr. Walker became an NPP physician, Anthem significantly reduced the "Allowable Amount" for Dr. Walker for the same services he had previously provided as a PP.

54. From $299.97[16] per visit, Anthem and CalPERS reduced the "Allowable Amount" to a range between $136.86 to a low of $76.91, i.e., which is equal to 45.6% to as little as 25.6% of the "Allowable Amount" that Anthem previously calculated. **Exhibits 27, 29-32, 34, 36, 38.**

55. CalPERS and Anthem calculated the "out-of-network" "Allowable Amount" from May 2008 to December 31, 2010 at $113.31 per visit. **Exhibit 23.**

56. CalPERS and Anthem calculated the "Allowable Amount" from January 1, 2010 to July 31, 2011 at $128.41 per visit. **Exhibit 23.**

57. CalPERS and Anthem calculated the "Allowable Amount" from August 1, 2011 to November 22, 2013 at $76.91 per visit. **Exhibit 23.**

58. CalPERS and Anthem calculated the "Allowable Amount" from May 3, 2013 to December 31, 2014 at $136.86 per visit. **Exhibit 23.**

59. Moreover, CalPERS and Anthem represented in writing that the "Allowable

[15] Anthem could not contract with Dr Walker at a rate less than the UCR rate. See infra.
[16] At one time, the rate was $320 a visit.

Amount" for 2010 would be $228.41 per visit, but never paid this amount.[17] **Exhibit 3, page 2.** With no notice of reconsideration or change, CalPERS and Anthem simply failed to reimburse Heinz at that higher rate. **Exhibits 27, 29-32, 34, 36, 38.**

60. For example, under the "Allowable Amount" rate of $136.86 per visit from 05/03/13 to 08/29/14, (i) Heinz was required to pay Dr. Walker's minimum fee of $275 in full; (ii) Anthem then offered to reimburse Heinz for 60% of the "Allowable Amount" of $136.86 (Anthem reimbursed approximately $82.12); (iii) leaving Heinz responsible for paying both the 40% of the "Allowable Amount" (approximately ($54.74) plus an additional $138.14 (the difference between Dr. Walker's minimum $275 charge and the $136.86 allowable rate), for a total out-of-pocket cost to Heinz of $192.88. **Exhibit 23, 34, 36, 38, 54.**

61. Under the "Allowable Amount" rate of only $76.91 per visit from 10/06/11 to 11/22/13, (i) Heinz was required to pay Dr. Walker's minimum fee of $275 in full; (ii) Anthem then offered to reimburse Heinz for 60% of the "Allowable Amount" of $76.91 (Anthem reimbursed approximately $46.15); (iii) leaving Heinz responsible for paying both the 40% of the "Allowable Amount" (approximately ($30.76) plus an additional $198.09 (the difference between Dr. Walker's minimum $275 charge and the $76.91 allowable rate), for a total out-of-pocket cost to Heinz of $229.85. The cost was $46.15 for Anthem. **Exhibits 23, 32, 34, 36, 54.**

62. Even though Anthem represented that it would pay 60% of the "out-of-network" costs under the PPO coverage, CalPERS and/or Anthem manipulate the rate of the "Allowable Amount" to greatly reduce the actual reimbursement to policyholders, in an unconscionable, substantively unfair manner that breaches their contract and obligations, including to those to whom they owed a fundamental duty.

63. Specifically, between 2008 to 2010, CalPERS and Anthem paid an "Allowable Amount" of $113.31 instead of $ 299.57, for an underpayment for each service visit (before applying the Plaintiff's forty percent (40%) co-pay) of about $186.26. The "Allowable Amount" in 2008 to 2010 was calculated at 37.8% of the contracted rate or "Allowable Amount" when Dr.

[17] CalPERS and Anthem should also be estopped, equitably and otherwise, from reducing the reimbursement rates and or "Allowable Amounts" to less that the highest that it represented, i.e. they represented that the "Allowable Amount in 2010" would be $228.41. **Exhibit 3, p. 2.**

Walker was "in plan." **Exhibits 14, 23, 27, 29, 30, 31.**

64. Specifically, in 2010 to July 2011, CalPERS and Anthem paid an "Allowable Amount" of $128.41 instead of $ 299.57, for an underpayment for each service visit (before applying the Plaintiff's forty percent (40%) co-pay) of about $171.16. The "Allowable Amount" in 2010 to July 2011 was calculated at 42.8% of the contracted rate or "Allowable Amount" when Dr. Walker was "in plan." **Exhibit 23, 29, 30, 31, 54.**

65. Specifically, in August 2011 to November 2013, CalPERS and Anthem paid an "Allowable Amount" of $76.91 instead of $ 299.57, for an underpayment for each service visit (before applying the Plaintiff's forty percent (40%) co-pay) of about $222.66. The "Allowable Amount" from August 2011 to November 2013 was calculated at 25.6% of the contracted rate or "Allowable Amount" when Dr. Walker was "in plan." (This large and unexplained further reduction in the "Allowable Amount" occurred after Heinz filed a grievance.) **Exhibits 23, 32, 34, 36, 38, 54.**

66. Specifically, in December 2013 through 2014, CalPERS and Anthem paid an "Allowable Amount" of $136.88 instead of $299.57, for an underpayment for each service visit (before applying the Plaintiff's forty percent (40%) co-pay) of about $162.69. The "Allowable Amount" from December 2013 through 2014 was calculated at 45.6% of the contracted rate or "Allowable Amount" when Dr. Walker was "in plan." **Exhibits 23, 34, 36, 38, 54.**

67. When Dr. Walker was a Preferred Provider under the Anthem plan, providing the exact same medical services in the same medical provider market, Heinz was only responsible for paying approximately $60 per visit.

68. When Dr. Walker was out of plan, by a combination of (i) the greatly reduced "Allowable Amount" and (ii) the higher percentage of co-pay (which was dependent on and a percentage of the "Allowable Amount"), Heinz was responsible for paying between $222.66 and $171.16 per service visit.

69. CalPERS' and Anthem's great reduction and recalculation of the "Allowable Amount" on "out-of-network" services is responsible for all of the inappropriate increased costs that CalPERS and Anthem wrongly caused Heinz and the class to bear.

70. Using the benchmarks for reimbursement on FairHealth.org, CalPERS' and Anthem's reimbursement rates for non-emergency "out-of-network" medical expenses are substantially below industry benchmark and substantially below the usual, customary, and reasonable rates. **Exhibit 61.**

71. More specifically, using FairHealth.org as a readily available benchmark for more proper reimbursement rates for the services that Heinz received, FairHealth.org supports that the "Allowable Amount" for a 45 to 55 minute session of Dr. Walker's services was $200 in Heinz's zip code. Under FairHealth.org, the estimated UCR charge for cognitive services (90837) in San Francisco was two hundred dollars ($200.00) per session. Under FairHealth.org, the Medicare baseline reimbursement was two hundred dollars ($200.00) per session. **Exhibit 61.** CalPERS and Anthem instead used an "Allowable Amount" of between $136 and $76 dollars. **Exhibits 3-23, 27, 28-32, 34-, 36, 38, 54.**

72. By artificially reducing the "Allowable Amount," CalPERS and Anthem forced Heinz to pay much more, with the result that Anthem and CalPERS unlawfully paid much less.

III. CalPERS' and Anthem's Representations in Standardized Forms and Contracts of Adhesion

73. The content of CalPERS' standardized PPO inducements and other publications has remained substantially the same over the period between January 2006 and December 2014. **Exhibits 24-26, 28, 39 -53, 55, 60.**

74. The PPO coverage offered by CalPERS and Anthem was explicitly directed at, and the only coverage made available to, those CalPERS members who were seeking health insurance benefits for non-emergency care by "out-of-network" physicians. CalPERS' and Anthem's promotional materials have been consistent through the time period. **Exhibit 24-26, 28, 39 -53, 55, 60.**

75. Consistently from 2006 to 2014, CalPERS and Anthem represented in their Evidence of Coverage (EOC), which was made available after contracting, that it/they would calculate the "Allowable Amount" at the same rate for PPO providers as Non-PPO providers. **Exhibits 24-26, 28, 41-45.**

76. In their publications, forms and each year's detailed Evidence of Coverage ("EOC") booklet for a particular PPO plan, CalPERS and Anthem represented that they were offering a PPO plan that was consistent with industry standards, including that they would provide benefits at a specific percentage of the usual, customary and reasonable (UCR) rate and/or appropriate reimbursement amounts. **Exhibits 3-55, 59-60.**

77. CalPERS and Anthem represented in the EOCs that the deductible or co-pay would increase 100% when using "out-of-network" service providers (from 20% to 40%).

78. CalPERS and Anthem fail to disclose by example or otherwise that the single biggest detriment involved in buying a PPO plan and then "going "out-of-network"" is a greatly reduced "Allowable Amount."

A. Representations That Allowable Amounts Would Be the Same "In-Network" or "Out-of-Network"

79. By way of example consistently applied, from 2006 to 2014, CalPERS and Anthem represented that it/they would calculate the "Allowable Amount" at the same rate for PPO providers as Non-PPO providers. For example, page 25 of the Evidence of Coverage (EOC) for the PERSCare Basic Plan Preferred Provider Organization effective January 01, 2008 – December 31, 2008 reads:

	Preferred Provider	Non -Preferred Provider
Allowable Amount - the allowance or negotiated amount under the Plan for service provided (see definition on page 91). Note this is only an example. "Allowable Amount" varies according to procedure and provider of service	$35,000	$35,000

(Exhibit 24, page 25, PERSCare Plan 2008)

80. This identical chart is also presented in the PersChoice Basic Plan EOC for January 1, 2009 covering the period of January 1 2009 to December 31, 2009. **Exhibit 25, page 31**, 2009 PERSChoice Plan.

81. This identical chart is also presented in the PERSChoice Basic Plan EOC for January 1, 2009 covering the period of January 1 2010 to December 31, 2010. **Exhibit 25 and Exhibit 26, page 31**, 2010 PERSChoice Plan.

82. The identical chart is also presented in the PERSChoice Basic Plan Preferred Provider Organization evidence of coverage effective January 1, 2011 – December 31, 2011. **Exhibit 44, page 26**, 2011 PERSChoice Plan.

83. A nearly identical chart is also presented in the PERSChoice Basic Plan Preferred Provider Organization EOC effective January 1, 2012 – December 31, 2012. **Exhibit 43**, page 26, 2011 PERSChoice Plan. The numbers have changed *but the parity of Allowable Amounts between the two categories remains the same.*

	Preferred Provider	**Non-Preferred Provider**
Allowable Amount - the allowance or negotiated amount under the Plan for service provided (see definition on page 91). Note this is only an example. "Allowable Amount" varies according to procedure and provider of service	$75,000	$75,000

84. A nearly identical chart is also presented in the PERSChoice Basic Plan Preferred Provider Organization EOC effective January 1, 2013 – December 31, 2013. **Exhibit 45,** page 27, 2013 PERSChoice Plan. Again, the numbers have changed *but the parity of Allowable Amounts between the two categories remains the same:*

	Preferred Provider	**Non -Preferred Provider**
Allowable Amount - the allowance or negotiated amount under the Plan for service provided (see definition on page 91). Note this is only an example. "Allowable Amount" varies	$85,000	$85,000

according to procedure and provider of service		

85. The material terms that were represented were that "Allowable Amount" should have been the same, resulting in the following:

	Heinz when Dr. Walker was a Preferred Provider	**Heinz when Dr. Walker was NOT a Non - Preferred Provider**
Billed Charge- the amount the provider actually charges for the covered service provided to a Member	$420	$420
Allowable Amount - the allowance or negotiated amount under the Plan for service provided (see definition on page 91). Note this is only an example. "Allowable Amount" varies according to procedure and provider of service	**$ 299.57**[18] (**EX 14**, page 3)	**$ 299.57** (**EX 14**, page 3)

B. Anthem and CalPERS Secretly Calculated "Allowable Amount" at a Huge Discount

86. Instead, the calculation of the "Allowable Amount" is drastically reduced for participants who have used non-PPO providers or incurred "out-of-network" expenses.[19]

87. Therefore, for Heinz,[20] the reality was:

[18] Walker was billed at $420, but his "Allowable Amount" in-network was around $320 at its peak, and $299.57 at an earlier point in time.

[19] At the same time and without any explanation or logic, Anthem and CalPERS afforded a higher "Allowable Amount" to a Ph.D.-holding practitioner *in Dr. Walker's practice* than to the services of Dr. Walker, a board-certified physician with more experience.

[20] Potential enrollees were not provided with the EOC before choosing plans. Instead, they received only marketing materials and summaries that gloss over any particulars about the "Allowable Amount" and how it is determined. In addition, once a participant was enrolled, the participant must act affirmatively to request a copy of the EOC.

	Heinz when Dr. Walker was a Preferred Provider	Heinz when Dr. Walker was NOT a Non -Preferred Provider
Billed Charge- the amount the provider actually charges for the covered service provided to a Member	$420	$420
Allowable Amount - the allowance or negotiated amount under the Plan for service provided (see definition on page 91). Note this is only an example. "Allowable Amount" varies according to procedure and provider of service	**$ 299.57** **(EX 14, page 3)**	**$113.31 (2008-2010)** **$128.41 (2010-07/11)** **$76.91 (8/11-11/2013)** **$136.86 (5/13-present)** **Exhibit 23**, page 1

88. Then Heinz was paid, as the plan clearly provides, 60 percent of the reduced Allowable Amounts.

C. **Representations of "Plan Payment", Reimbursement, and Other Terms Based on Allowable Amount**

89. The PPO plan documentation does not put one on sufficient notice of the changed "Allowable Amount," the hidden exclusion of reduced "out-of-network" reimbursement, and reduced reimbursement, especially to the level of disclosure required by a fiduciary or in an insurance contract. **Exhibit 24-26, 28, 41-53, 55.**

90. The EOCs provide that the difference between reimbursement for "in-network" care and "out-of-network" care would be in the percentage of reimbursement of the "Allowable Amount." **Exhibits 24-26, 28, 41-53, 55.** Buyers of PPO plans expect to receive overall a smaller reimbursement amount because they have to pay a greater percentage of the "Allowable Amount" for "out-of-network" medical expenses, but they expect the difference to be built into the differing percentage of the co-pay but not also suffer a large reduction in the "Allowable Amount." **Exhibits 1-23, 54.**

91. The "Plan Payment" is the percentage of the "Allowable Amount" that CalPERS or Anthem will pay. Since the "Plan Payment" (in the EOC and other documentation) is calculated at 60 percent of the "Allowable Amount," the amount of the Plan Payment is reduced in tandem percent-wise as the "Allowable Amount" falls. The reduced "Allowable Amount" starts a cascade of substantially lower reimbursements. **Exhibits 3-55, 59, 60, 61.**

D. Definition of Allowable Amount

92. The "Allowable Amount" is defined in the Evidence of Coverage for each year. See **Exhibits 14, 23, 24-26, 28, 41-45, 54.**

93. The "Allowable Amount" definition granted Anthem the right to set the "Allowable Amount" at the lesser of the Billed Charge ($420 in Dr. Walker's case) or the amount defined in one of three subparts:

(1) The amount appropriate in the geographic area based on evaluation of the market considerations (this should be similar to Dr. Walker's contract rate of $299.72);

(2) The amount that Anthem agreed to accept as payment (Dr. Walker's contract rate was $299.72);

(3) If not determined in either (1) or (2) the amount that Anthem determines is **appropriate** considering the circumstance and services rendered.

94. The first two of the three subparts of the "Allowable Amount" definition are consistent with a reasonable reimbursement rate (i.e. $299.72). The third has an appropriateness standard that should be consistent with the first two subparts.

95. More specifically, the definition of "Allowable Amount" in the EOC for the PERSCare Basic Plan Preferred Provider Organization effective January 01, 2008 – December 31, 2008 (**Exhibit** 24) is

"1. the amount that Blue Cross of California or the local Blue Cross and/or Blue Shield Plan has determined is an **appropriate payment for the service(s) rendered in the provider's geographic area, based on such factors as the Plan's evaluation of the**

value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

"2. such other amount as the Preferred Provider and Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan **have agreed will be accepted as payment** for the service(s) rendered; or

"3. if an amount is not determined as described in either (1) or (2) above, the amount that Blue Cross of California or the local Blue Cross and/or Blue Shield Plan **determines is appropriate considering the particular circumstances and the services rendered**."

96. Under these terms, the "Allowable Amount" should have been calculated the reasonable and appropriate rate available under one of the three subparts of the definition:

1) In the amount of the prior agreed-upon fee by Dr. Walker when in-network ($299.57) under subsection (b) of the definition, or

2) Otherwise related to the value of other services, market considerations, and provider charge patterns under subsection (a) (which should be consistent with the $299.57 agreed upon fee by Dr. Walker when in network), or

3) An appropriate and reasonable amount considering the particular services rendered under subsection (c) of the definition (which should also be consistent with the agreed upon fee by Dr. Walker when in network or the UCR rate).

97. Each of these subparts should provide a similar or identical "Allowable Amount." The appropriateness standard in the third part should result in an "Allowable Amount" that is consistent with the first two subparts. **Exhibits 24-26, 28, 41-45, 61.**

98. There is no disclosure that the third subpart of the definition would provide a significantly reduced calculation of the "Allowable Amount." **Exhibits 3-55, 59-60.**

99. Although 28 CCR §1300.711(a)(3)(C) holds the amount set forth in the enrollees' Evidence of Coverage controls reimbursement for out-of-network non-emergency services, that only applies to clear and patent terms that are consistent with the other terms. CalPERS and Anthem should not be allowed to focus solely on the third subpart of the "Allowable Amount"

definition in the EOC and ignore the other terms and examples in the EOC that require identical or higher reimbursement. CalPERS and Anthem fail to harmonize and give effect to all of the terms in the EOC when they say that the third subpart is the only relevant part and it allows Anthem complete discretion to determine an "Allowable Amount" as Anthem sees fit.

100. The *Orthopedics Specialist* case (a *quantum meruit* case expressly not based in contract) is not applicable. Its dicta, that the terms in the EOC contract control even if the terms are not fair (or unclear), is not on point or controlling.

101. CalPERS and Anthem cannot string together a series of technicalities that purportedly allow CalPERS and Anthem to provide greatly reduced reimbursements irrespective of other terms requiring a higher reimbursement consistent with UCR and industry standards.

102. The examples and other terms in the EOC represent that the "Allowable Amounts" will be identical for medical services whether in plan or out of plan, and those terms and examples must also be given effect, even under 28 CCR §1300.71. The "Allowable Amount" definition must be construed consistently with the other two subparts of the "Allowable Amount" definition such that the reimbursement should be based in contracted rates or the appropriate UCR rates.

103. The third subpart is so vague and ambiguous without standards as to be not a recognizable or defined term in the EOC under 28 CCR §1300.71, including as it is inconsistent with other express patent terms and examples, and without standards. 2 CCR §510.598 regulations require that CalPERS reimburse for the majority of the usual, customary, and reasonable rates.

104. In the third subpart of the "Allowable Amount" definition, to the extent that Anthem can unilaterally determine an "appropriate" standard, the language and placement is so vague, unilateral, and self-serving without any benchmarking that it fails to provide standards for performance and renders the EOC an illusory contract. **Exhibits 24-26, 28, 41-45 and 46 -53.** The third subpart does not itself provide any terms under 28 CCR §1300.71 because unfettered discretion is not a term.

105. The "Allowable Amount" must be reasonable, including related to the value of

service considering market conditions, the prior contract rates, etc. To save the contract from being void for vagueness, a judge would need to excise this third subpart, deem "appropriate" to signify the "appropriate UCR" rate, or at a minimum impose some objective standards that the "Allowable Amounts" must be reasonable and consistent with the two other subparts.

106. Neither the language nor the placement of the appropriateness language in the third subpart allows Anthem or CalPERS unfettered discretion to calculate the "Allowable Amount" at a fraction of a (1) contract rate; (2) the agreed rate, (3) the UCR rate, or (4) other prevailing industry standards. **Exhibits 1-61.**

E. "Appropriate" Requires Benchmarks

107. Indeed, a reimbursement rate that is not based on value of the service relative to the value of other services, market considerations, and provider charge patterns, the agreed upon rate, and other usual, customary, and reasonable rates could not be "appropriate."

108. Stated differently, to be "appropriate," CalPERS would have to require Anthem to use adequate "usual, customary, and reasonable" (UCR) reimbursement rates. Instead, CalPERS acquiesced in Anthem's use of "inappropriate" and unreasonably low "Allowable Amounts" and thereby provided "inappropriate" unreasonably low reimbursement rates. The "inappropriate" arbitrary rates caused Heinz and other members to pay more than the plan document allow.

109. **CalPERS' and Anthem's Failure to Use Appropriate Benchmarks.** To satisfy the "appropriate" language in the CalPERS and Anthem "Allowable Amount" definition, CalPERS and/or Anthem must use reasonable industry standards for each of the subparts in the definition, including, as the adhesion contract must be construed reasonably and in favor of the non-drafting beneficiary.

110. Instead of using appropriate standards, and indeed failing to provide any standards, Anthem and CalPERS instead used an arbitrary and capricious "Allowable Amount" that was purportedly calculated by some proprietary software of unknown origin.[21] Although

[21] It is unclear if the software was proprietary to Anthem or was a database created by Ingenix or another provider. It is odd that the software would reduce the "Allowable Amount" so much (from $128.41 down to $76.91) in such a short period.

requested, no evidence was provided to support the calculation.[22]

111. CalPERS simply accepted the "Allowable Amount" as purportedly determined by Anthem's computers. **Exhibit 1**, Final Decision.

112. As calculated by CalPERS and Anthem, the "Allowable Amount" is inconsistent with the EOC, inconsistent with the actual reasonable charges by providers in the area, and contrary to law.

113. There is no notice that Anthem and CalPERS do not consider themselves bound by reasonableness or consistency when applying the "appropriate" standard.

114. **Standards for Reasonable Reimbursement in Knox Keene Act, Regulations.** The Department of Managed Health Care (DMHC) has set the standards for minimum reimbursement of emergency care, including reasonable and customary value in 28 CCR §1300.71.

115. Although Section 1300.71(a)(3)(C) provides that reimbursement for non-emergency services are set forth in the EOC, CalPERS' and Anthem's EOC and their policies and practice regarding the "Allowable Amount" and the reimbursement rates are unclear, vague, contradictory and fail to provide standards or an "appropriate" reimbursement rate. For example, since the third subpart of the "Allowable Amount" definition in the EOC contradicts the examples, contradicts other parts of the definition, is vague (and ambiguous) at best, then the clearer UCR standards in Regulations §1300.71 should apply.[23]

116. Sections of 1300.71 provide benchmarks for reimbursement for noncontracted providers. The reimbursement of a claim means "the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's

[22] Anthem represented that it reviewed the other rates for similarly situated doctors in the locality, but no evidence supported Anthem's claim that it took any independent review.
[23] The contract says what it says. (*Orthopedic Specialists, supra*, at 648.)

practice that are relevant; and (vi) any unusual circumstances in the case ...." (§1300.71(a)(3)(B); *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1267–68.)

F. CalPERS' Other Communications, Forms and Publications Fail to Contain Adequate Disclosure

117. Throughout the relevant period, CalPERS' and Anthem's other communications, forms and publications fail to contain adequate disclosure and fail to inform Plaintiffs of the material terms of the PPO arrangement. **Exhibits 3- 55, 59-60.**

118. Throughout the relevant period, CalPERS and Anthem failed to make information available to Plaintiffs to apprise them of the material terms. This was particularly true in the period when enrollees are choosing the health plan that they will join.

119. Plaintiffs paid additional amounts for PPO coverages, including to receive the right to reimbursement of "out-of-network" medical services at (1) appropriate reimbursement rates, (2) at UCR rates, (3) industry standard rates, or (4) to receive appropriate "Allowable Amount" rates. **Exhibits 39-40, 55, 59.**

120. Plaintiffs could not learn of the changed calculation of the "Allowable Amount", the greatly reduced reimbursement, the hidden policies and practices, the change in material terms, risks, offsets, or other adverse reimbursement practices or policies, including as these were secret internal CalPERS and Anthem policies and practices that CalPERS and Anthem failed to disclose. CalPERS and Anthem represented them as "trade secrets" or proprietary[24].

121. Plaintiffs are presumed to have relied on CalPERS' and Anthem's representations regarding the parity between "Allowable Amount" calculations for in network and out-of-network service that CalPERS and Anthem made in its standardized forms, publications, and contracts. (See *Estate of Gump* (1991) 1 Cal.App.4th 582, 601; *Edmunds v. Valley Circle Estates* (1993) 16 Cal.App.4th 1290, 1302.)

122. For reference, a listing of CalPERS and Anthem's communications by exhibit:

[24] For example, in the administrative process, CalPERS and Anthem refused to provide information about the policies, practice or other data indicating that they were confidential, proprietary, and "trade secrets."

Exhibit List for Complaint

Number	Title
1	CalPERS final administrative decision, with denial of reconsideration
2	VCA filing notice- no jurisdiction
3	CalPERS April 30, 2010 letter to Heinz
4	Heinz's May 26, 2010 Letter to Heinz
5	Anthem Statement May 2008 , Claim Form, Walker Bill charging $420 for 45 to 50 min session and listing cognitive service at 90807 as CPT code,
6	Anthem Statement June 2008
7	Anthem Statement for July August 2008
8	Anthem claims processing December 2008
9	Anthem statement September 2008
10	Anthem statement November December 2008
11	Anthem Statement January to April 2009
12	Heinz Member Grievance Form September 2008
13	Anthem reply re grievance rec 10-22-2008
14	Appeal received 11/07/08 inquiry detail , on second page reads:' this member has seen the same Dr. under a different PPO tx id # and the contracted rate was $$299.57 for 90807
15	Anthem's denial to Heinz grievance and response to appeal rec 11/7/08, and indicating to Heinz to change his doctor
16	Heinz first appeal on November 24, 2008 to Anthem after Anthem denial
17	Anthem's revised denial of January 27, 2009
18	Anthem receipt and recognition of second appeal, April 15, 2009
19	Heinz renewed and continued appeal letter of June 15, 2009, including Anthem April 15, 2009 denial, and Anthem's response to Heinz's appeal on January 27, 2009
20	Heinz demand letter to CalPERS, for nonaction, checking up on grievance December 27, 2009
21	Heinz demand letter to CalPERS checking on Anthem grievance March 17, 2010, submitting documentation on under-reimbursement
22	Heinz demand letter to CalPERS requesting follow-up on grievance dated April 22, 2010
23	Anthem inquiry tracking indicating that the allowable amount between 2008 -2010: $113,31. The allowable amount from 2010 to 7/28/11 was $128.41, From 11/08/11 to 11/22/13 :$76.91 and 05/03/13 - current (8/29/14): $136.86
24	Evidence of Coverage (EOC) for 2008
25	Evidence of Coverage (EOC) for 2009
26	Evidence of Coverage(EOC) for 2010
27	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2008
28	Evidence of Coverage(EOC) for 2014
29	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2009-2010

30	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2010
31	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2010-2011
32	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2011-12
33	Heinz's demand for information
34	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2012-2013
35	Public Records Request for info
36	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2013
37	CalPERS PRA response
38	Heinz's medical claims, appeal, processing, presentation and reimbursement for 2014
39	Heinz open enrollment form and standardized process $955 premium
40	Heinz open enrollment standardized form 2009 $1488 premium
41	Addendum to EOC (2012)
42	Addendum to EOC (2011)
43	Evidence of Coverage (2012)
44	Evidence of Coverage (2011)
45	Evidence of Coverage (2013)
46	Summary of Health Benefits Promo 2012
47	Summary of Health Benefits Promo
48	Summary of Health Benefits (2014)
49	Summary of Health Benefits (2011)
50	Summary of Health Benefits (2010)
51	Summary of Healthy Benefits (2011)
52	Summary of Health Benefits (2008)
53	Summary of Benefits PERS choice 2009
54	CalPERS PRA response- Administrative process ongoing to present
55	CalPERS circular letter re open enrollment PPO coverage
56	Litigation Hold letters for Electronically Stored Info (ESI)
57	Litigation Hold letters for Electronically Stored Info (ESI)
58	State of New York Attorney General Ingenix litigation information
59	Difference in premiums for PPO coverages
60	CalPERS Facts at a glance, page 7 indicates that 25.7 percent of CalPERS members enroll in PPO coverage or about 365,572 members.
61	Fair Health data on UCR rates show a $200 Estimates charge which is equivalent to Allowable Amount for 60 minutes of Psychotherapy service coded 90837 in SF and a Medicare reimbursement rate of $200 as well

G. CalPERS' Standardized Intake Process

123. To inform Plaintiffs and to process Plaintiffs' application to obtain coverage under the Anthem medical insurance plans offered by CalPERS, CalPERS and Anthem consistently required Plaintiffs to utilize the standardized forms and had a standardized intake process that

was non-negotiable. CalPERS and Anthem exclusively used standardized forms.

124. **Standardized Processing of Claims.** CalPERS and Anthem consistently required Plaintiffs to submit claims for reimbursement in a process that was non-negotiable. **Exhibits 3-23, 27, 29-38.** CalPERS and Anthem exclusively used standardized processing of the claims pursuant to standardized reimbursement policies and practices. Heinz presented and exhausted CalPERS' and Anthem's processes.

125. **Standardized Medical Claims and Procedure Coding.** Medical claims are standardized and administered by standardized numerical codes. **Exhibits 14, 23, 27, 29-32, 34, 36, 38, 54.** For example, medical procedures are coded by physicians or their offices pursuant to standardized codes, including Current Procedural Terminology (CPT) codes. (*California Insurance Guarantee Ass. V. Workers Comp Appeal Bd.* (2014) 232 Cal.App.4th 543.) Each CPT code identifies a particular medical procedure, and in addition, there are standardized codes for each claim.

FAIR HEALTH REIMBURSEMENT STANDARDS AND OTHER AVAILABLE; DATA ON APPROPRIATE REASONABLE REIMBURSEMENT

126. For the services that Brad Heinz receives, there is comparable data to establish the adequate usual, customary, and reasonable rates. For example, FairHealth.org reimbursement data supports that the "Allowable Amount" fee for a 45 to 50 minute session of Dr. Walker's services was $200 in Heinz's zip code. **Exhibit 61.**

127. Anthem's/CalPERS' reimbursement rates can also be compared with the rates for the same or similar services rendered in the same locality that are readily available in the FairHealth.org and other comparable databases.

128. CalPERS regulation refers to the Relative Value Studies of the California Medical Association, but the CMA has not published the Relative Value Studies since at least the 1980's. There is no current Relative Value Study by the CMA.

129. Although the specific problems in CalPERS' and/or Anthem's data, policy, practice or method for determining the greatly reduced "Allowable Amount" are not presently known to Plaintiffs, the issues regarding inadequate reimbursements based on incorrect

Allowable Amounts or references to other medical expenses have been litigated before. For example, in cases challenging the reasonableness of reimbursements, the specific criticisms of claims processing in Ingenix were summarized into three broad categories. First, that Ingenix did not audit the data provided by insurers to make sure that the charges properly reflect what providers actually charge in the marketplace. Second, that Ingenix used statistically invalid "edits" to exclude a disproportionate amount of high charges from its UCR calculations. Third, that Ingenix "lumps" charges for the same service together regardless of whether the service was provided by a certified specialist with many years of experience or a less experienced physicians such that the aggregate UCR rate calculated by the database was artificially low.

130. The Assurance Order required that the industry stop using the Ingenix database and spend $50 million to create a "new, independent database, not controlled by any insurer, to be used for determining fair and accurate reimbursement rates." The Assurance Order also announced the establishment of a "Healthcare Information Transparency Website" ("HIT Website") to inform and educate the public about reimbursement rates. The "new" database to replace Ingenix was to be funded by contributions from the following insurers: UnitedHealth Group ($50 million), Aetna ($20 million), Wellpoint ($10 million), CIGNA ($10 million), MVP Health Care Inc. ($535,000), Independent Health ($475,000), and HealthNow ($212,500).

131. The independent not-for-profit created by the Assurance Order to establish and run a new database to replace Ingenix is called "FAIR Health, Inc." (which stands for "Fair and Independent Research"). FAIR Health was created to serve as "an independent, objective, and transparent source of healthcare reimbursement data for consumers, insurers, healthcare providers, researchers, and policymakers." Like Ingenix, the FAIR database is a "national database of millions of de-identified healthcare claims ... submitted directly to FAIR Health by insurers and other healthcare payors." The "paramount goal," however, is transparency and integrity.

132. FAIR has also created the "FAIR Health Consumer Cost Lookup," targeted towards consumers, which consists of a "free, user-friendly website whereby patients can estimate the out-of-pocket expenses they will incur if they seek "out-of-network" care."

CLASS ACTION ALLEGATIONS

I. Class Action is Appropriate

133. The legal issues, including about whether the placement and language of the third subpart of the "Allowable Amount" definition in the EOC allows CalPERS and/or Anthem unfettered discretion to calculate the "Allowable Amount" and the reimbursement at greatly reduced rates, are similar or identical across the class.

134. Each class member was enrolled or covered under CalPERS or Anthem PPO insurance, such as PERSCare, PERSChoice, PERSSelect or similar PPO coverage.

135. Each class member enrolled in the PPO coverage using the same or similar standardized forms.

136. Each class member was bound by the same or similar EOC.

137. Each class member submitted claims for out-of-network medical expenses to CalPERS and Anthem and received reimbursement at an unreasonable rate that was below industry standards.

138. CalPERS and/or Anthem breached the contract in the same or similar way, by failing to provide proper reimbursement.

139. The class members suffered under-reimbursement based on CalPERS' and/or Anthem's application of same or similar policy, practice, paradigm, standards, formulas, or theories, or use of the same or similar source of information, data, or computer program.

140. CalPERS and/or Anthem utilized the same or similar policy, practice paradigm, standards, formulas, theories, source of information, data, or computer program when it calculated the Allowable Amounts for the CalPERS Anthem PPO coverage for "out-of-network" medical expenses at an improperly reduced rate.

141. CalPERS and Anthem caused the class members injuries in the same or similar way, by using inappropriately low Allowable Amounts to reduce reimbursement for out-of-network medical services.

142. The class members are similarly situated as they each suffer similar or common injuries of reduced reimbursement for "out-of-network" medical expenses that were presented

and paid by Anthem and/or CalPERS, albeit at a reduced rate.

143. CalPERS and/or Anthem breached their contractual duties to Plaintiffs in the same or similar manner.

144. CalPERS and/or Anthem were unjustly enriched, et al in the same or similar fashion.

145. The representations in Anthem's and CalPERS' documents and non-negotiable form contracts were standardized and applied uniformly over specific long periods of time.

146. CalPERS owed and still owes the same or similar fiduciary duties to all class members.

147. CalPERS' breaches its fiduciary duties, including the duty to inform, duty of good faith and fair dealing, the duty to account, the duty of loyalty, duty to not take advantage, and other fiduciary duties are in the same or similar manner for all class members. For example, CalPERS breaches it duty of loyalty to all class members in the same or similar manner when it offers or pays compensation for Anthem performance as it relates to reducing the reimbursement below reasonable levels.

148. The presumption of Plaintiffs' reliance on Anthem, CalPERS, and CalPERS' representations were the same or similar for all class members.

149. CalPERS' breach of fiduciary duties proximately and directly caused Plaintiffs' harm in the same or similar manner, including based on the presumption of reliance.

150. Plaintiffs' claims for damages are the same or similar in cause and arise from the same or similar proximate cause, acts and omissions by CalPERS and/or Anthem.

151. Plaintiffs' claims for increased reimbursement, are the same or similar for all class members.

152. Plaintiffs' claims for interest from the date of under-reimbursement, and other relief to place them back in the position that they would have been is the same or similar for all class members.

153. Plaintiffs' claims for attorney fees and other relief is the same or similar for all class members.

154. CalPERS' defenses, including on the EOC, are the same or similar across the class.

155. Anthem's defenses, including that it offered appropriate reimbursement, are the same or similar across the class.

II. Manageability

156. A trial of the class action is manageable as the facts of each reimbursement are not disputed and are business records kept and maintained in CalPERS' or Anthem's electronic data or otherwise available by a search of electronic records that do not require individual review of files or re-determination of prior events.

157. The class is manageable at trial as the facts of the appropriate reimbursement for each medical services are available, including in well-known and available databases such as fairhealth.org.

158. The class should be certified as common legal and factual control predominate. CalPERS and/or Anthem's policies or practices are common to the class. The class is easily identified as those who sought reimbursement for out-of-network medical services under the PPO coverage from 2006 to the present. Heinz's claims for increased reimbursement are typical.

159. The legal issue(s) including whether the "Allowable Amount" definition allows the greatly reduced, unreasonable, and unconscionable reimbursement is common. Since the law holds that CalPERS and Anthem cannot hide exclusions and inconsistent terms in form adhesion contracts to provide results that are contrary to its other representations, Plaintiffs should prevail on the law. See infra at paragraphs 208- 297.

160. The facts exist to identify class members, identify CalPERS and/or Anthem liability for unreasonable reimbursements, identify with specificity the amount of damages each class member suffered, allow CalPERS and/or Anthem to assert its defenses individually or to the class, and otherwise to manage trial. Discovery will reveal that the coding, types, names, and dates of all medical services for each class member that Anthem and/or CalPERS already reimbursed in an out-of-network context. Each claim is already identified by standard codes by type and linked to the location and other data that CalPERS and/or Anthem used to pay the

claim, albeit at a reduced rate. A search of the Anthem and/or CalPERS computer records can retrieve all of the out-of-network claims paid over the time period, and anonymize them (for example by using numbers instead of names) so that any HIPPA or other confidential data is kept private. The retrieved data can be sorted by name, type, date, reimbursement, and other attributes in an Excel or similar spreadsheets.

161. After the data about the out-of-network claims and reimbursements is retrieved and organized, CalPERS' and or Anthem's liability and damages can be determined by accessing fairhealth.org or other database and retrieving the rate of the industry standard reimbursement for that type of claim as coded in the location at that time. As part of the administration of the claim originally, the standard coding for type or claim (or its equivalent) and the location (by zip code or otherwise) that Anthem paid can be retrieved. The retrieved claims data can be compared to the data in fair health or other database that reflects the amount of the industry standard reimbursement rates for the same or similar coding service or type in the location. Anthem would also have all of the data about rates for Anthem contracted providers performing like services in the same zip code. Comparing the amounts paid by CalPERS and/or Anthem with the industry standard data in Fair Health.org or other database can determine the amount of underpayment for each service. Once the amount of underpayment is determined by this comparison, then interest can be added to the amount of the under reimbursement corresponding to the date that the original claim was underpaid and continuing to the date of the resolution of this case.

162. The data is available in CalPERS' and Anthem's database to allow CalPERS and Anthem to assert their defense(s), individually and to the group.

163. There should be little or no statistical issues and no relevant variability between class members as all of the claims have already been paid, and the only issues are whether the reimbursement amount was correct. All of the information about each payment, the correct reimbursement rate, and the amount and timing of the underpayment should be retrievable, factually undisputed as business records, and determinably with sufficient precision for each claim by each class member.

III. The Class Meets the Requirements for Certification

164. **Harm and Loss.** Upon contracting for PPO insurance, all putative class members suffer harm and loss by CalPERS and/or Anthem forcing them to accept an undisclosed increased cost and under-reimbursement. The harm occurs prior to or at the point of contracting for PPO coverage that was presented itself as industry standard PPO coverage. Plaintiffs' subsequent under reimbursement quantified the harm that Plaintiffs have suffered for their under-reimbursement and damages.

165. **Ascertainable Class.** Members of the putative class are readily identified from files and computer databases maintained by CalPERS and /or Anthem. The class also includes enrollees, beneficiaries, and successors in interest to those individuals identified herein.

166. The litigation of the questions of fact and law involved in this action will resolve the rights of all members of the class and hence will have a binding effect on all class members.

167. Ascertaining who is included in the proposed class can be determined easily and with a high degree of precision on a class-wide basis. All of the information needed to determine ascertainability is or should be in CalPERS' and/or Anthem's possession, in CalPERS' and/or Anthem's electronic databases, or easily obtainable.

168. **Numerosity.** The class is numerous and joinder of all class members is impracticable due to the existence of complex issues resulting in the high cost of separate, individualized litigation in comparison to the amount of monetary recovery for individual class members.

169. CalPERS has 1.6 million active and retired Members.

170. Although the total number of people that have purchased PPO coverage contracts for the relevant period is not exactly known, CalPERS retains all the records that would be needed to identify the members of the class.

171. **Community of Interest.** The proposed class has a well-defined community of interest in the questions of law and fact to be litigated. Common questions of law and fact predominate in the liability issues, relief issues, and anticipated affirmative defenses.

172. For example, large issues in common include (i) CalPERS' breach of fiduciary

duties, including CalPERS' failure to adequately inform Plaintiffs of the reduced "Allowable Amount," (ii) CalPERS' breach of duty of loyalty, good faith, fair dealing, duty to not take advantage, duty to act in Plaintiffs' best interest, and duty to account, etc. including when offering or providing performance based compensation to Anthem to the extent that CalPERS participated in or motivated Anthem to reduce the reimbursement rates, (iii) presumption of reliance, (iv) Plaintiffs commonly seek reasonable and higher reimbursement for out-of-network medical services, (v) Plaintiffs suffered from the standardized form representations and elections by CalPERS which were inadequate under *O'Neal v. Stanislaus County* and *Hittle v SBCERA*, *supra*; (vi) CalPERS' breach of contract, unjust enrichment, etc.; (vii) CalPERS' failure to calculate the "Allowable Amount" appropriately, including in pursuant to the first two subparts of the definition, and pursuant to industry standards such as UCR (viii) CalPERS' omission of material terms, (ix) CalPERS' unlawful delegation to Anthem of the calculation of the "Allowable Amount" and amount of reimbursement; (x) in the common legal questions of whether the third subpart of the "Allowable Amount" definition gives CalPERS and/or Anthem unfettered discretion to establish an "Allowable Amount" that is substantially below industry standards, (xi) interest, (xii) delayed accrual, (xiii) attorney fees, and (xix) other issues raised in this case.

173. For example, large issues in common include (i) Anthem's breach of contract; (ii) Anthem's breach of the implied covenant of good faith, fair dealing etc., (iii) presumption of reliance; (iv) the adequacy of the standardized form representations by Anthem; (v) Anthem's breach of contract, unjust enrichment, unfair business practices, etc.; (vi) Anthem's failure to calculate the "Allowable Amount" appropriately, including pursuant to the first two subparts of the "Allowable Amount" definition, or to industry standards such as UCR; (vii) Anthem's omission of material terms; (viii) interest; (ix) delayed accrual; (x) attorney fees; and (xi) other issues raised in this case.

174. The differing amounts of damages suffered by different class members does not make the class uncertain or the class representative inadequate.

175. **Superiority of Class Adjudication.** The certification of a class in this action is

superior to the litigation of a multitude of cases by individual members of the putative class. Class adjudication will conserve judicial resources and will avoid the possibility of inconsistent rulings. Moreover, there are class members who are unlikely to join or bring an action due to, among other reasons, their inability to afford the prosecution of separate, individual actions.

176. The cases are impractical to litigate effectively as individual matters against CalPERS or its outside counsel, as the common legal issues are complex and require significant briefing and research. Individual cases cannot support the amount of novel legal work needed to resolve these matters.

177. Finally, equity dictates that all persons who stand to benefit from the relief sought herein should be subject to the lawsuit and hence subject to an order spreading the costs of litigation among the class members in relationship to the benefits received.

178. **Superiority of Class Action to Agency Determination.** CalPERS as a state agency is not empowered to adjudicate or resolve class actions or the rights of individuals (including proposed class members) that are not personally appearing before the agency. (*Rose v. City of Hayward* (1981) 126 Cal.App.3d 926.) As such, a class or representative action is the only way that the class members can get relief. Heinz presented and exhausted the class claims. CalPERS owes substantive duties to Plaintiffs in all venues, including this class action.

179. **Information Available or Known About Reimbursements, Dates, Amounts, Coding, Eligibility, Vesting, Dates.** For each claim of each Plaintiff and proposed class member, all data is available including but not limited to (i) the type and amount of the services rendered, (ii) the "Allowable Amount," (iii) the underpayment, (iv) the date of service, (v) the amount reimbursed, (vi) the UCR rate; and (vii) the other data are known or ascertainable from CalPERS', Anthem's or Fair health (or its equivalent) database or records.

180. For each claim of each Plaintiff and proposed class member, (i) the dates of medical expenses, (ii) the amount of medical expenses, (iii) the coding of the medical procedure, (iv) the reimbursement rates of the medical procedure, (v) the fair health equivalent cost or reimbursement of the medical procedure, (vi) the locale of the services rendered, (vii) name of the enrollee in PPO coverage, (viii) the date of enrollment, (ix) the medical services claims

presented, (x) the amount of the claim, (xi) the date of the claims, (xii) the type of procedure, (xiii) the date and acceptance of the claim, (xiv) reimbursement amount paid, (xv) the dates that payment was paid, (xvi) the "Allowable Amounts," (xvii) the contract amounts, if any, (xviii) the UCR rate by procedure by zip code or its equivalent; and (xix) all other relevant information, amounts or dates are or will become known or ascertainable from CalPERS', Anthem's, or Fairhealth.org (or its equivalent) database or electronic data and records, which are business records.

181. If information or dates are not presently know, they are or will be discoverable, ascertainable, or available with reasonable particularity, including from information or data available or present in one or more of CalPERS', Anthem's or Fair Health's (or its equivalent) database or electronic data and records.

182. For example, CalPERS' database or records possesses, maintains, or holds reliable information such that the reimbursement, the type of service and location of service can be readily and precisely computed, known, ascertained, or made reasonably available for each class member.

183. For example, Anthem's database or records possesses, maintains, or holds reliable information regarding the reimbursement, the type of service and location of service can be readily and sufficiently computed, known, ascertained, or made reasonably precise for each class member.

184. In addition, CalPERS' and Anthem's data contains the information that would allow CalPERS and/or Anthem to assert defenses individually and as a group, such that the Defendants would not be denied due process.

185. For example, FairHealth.org's (or its equivalent) database r possesses, maintains, or holds reliable information regarding the industry standard reimbursement rates for medical services including by location, so that together with the class and other data retrieved from CalPERS and/or Anthem, the amount of damages, interest, or other relief can be readily and sufficiently computed, known, or ascertained for each claim for each person, including without requiring individual review or redetermination of the "facts".

186. In addition, Plaintiffs have filed and maintained an electronically stored information (ESI) litigation hold letter with CalPERS and Anthem since 2011 to require CalPERS and Anthem to preserve the electronic data that is relevant or involved in this case. Plaintiffs have renewed that ESI hold letter recently.

IV. Facts Regarding the Class Representative

187. The facts of named Plaintiff Brad Heinz described herein are illustrative, including to show that he is an adequate class representative.

188. Heinz was an attorney who worked at the Administrative Office of the Courts (AOC) and was an employee of the State of California from 2002 to 2012.

189. Heinz is a CalPERS member. Heinz is a beneficiary of statutory and fiduciary duties owed to him by CalPERS, CalPERS' Board of Administration, and CalPERS' employees. CalPERS owed fiduciary duties to Heinz and the class, starting at first employment, prior to contracting for the PPO coverage and continuing to the present.

190. Heinz contracted with CalPERS and/or Anthem for PPO coverage, and performed all of his requirements under the contract.

191. Heinz enrolled in PPO insurance by form contract, visited an out-of-network provider, and submitted claims for reimbursement for out-of-network medical expenses that Anthem and/or CalPERS approved for reimbursement as described herein.

192. Heinz presented and exhausted all of the administrative or procedural requirements before filing suit.

193. **Adequacy of Class Representation.** Heinz is an adequate representative. He identifies and represents the main characteristics of the people who have suffered harm from CalPERS' and Anthem's policies, practices, acts, or omissions described herein. Heinz as the named Plaintiff has claims typical of all of the class members.

194. Heinz can fairly and adequately represent and protect the interests of the class. There is no conflict between his interests and the interests of other class members, this action is not collusive, Heinz and his counsel have the necessary resources to litigate this action, and counsel has the experience and ability required to prosecute this case as a class action.

195. Brad Heinz is an adequate representative for all class members including in part because he:

a) Is a CalPERS member;

b) Enrolled in the PPO coverage including PERSChoice, PERSCare, PERS Select for one or more of the years 2006 to the present offered by CalPERS and/or Anthem **(see for example Exhibits 27, 29 -32, 34, 36, 38 -40);**

c) Enrolled via standardized materials and forms[25] (see for example **Exhibits 39 - 40);**

d) Submitted claims for non-emergency "out-of-network" medical services that CalPERS and/or Anthem accepted and reimbursed (see for example; **Exhibits 3-23, 27, 29-40, 54);**

e) Suffered harm directly, indirectly, proximately, and arising from acts or omission by CalPERS and/or Anthem, including about the reimbursement practices, including the calculation of a reduced Allowable Amounts (see for example **Exhibits 3-23, 27, 29-40, 54, 61);**

f) Suffered harm directly, indirectly, proximately, and arising from the breach of CalPERS' fiduciary duties of loyalty, accounting, good faith, fair dealing, etc. (see for example **Exhibits 3-23, 27, 29-40, 54, 61);**

g) Suffered harm directly, indirectly, proximately, and arising from the breach of contract by Anthem (see for example **Exhibits 1-61);**

h) Suffered harm directly, indirectly, proximately, and arising from the breach of contract by CalPERS (see for example **Exhibits 1-61);**

i) Suffered from CalPERS' and/or Anthem's unjust enrichment, breaches of duties of good faith and fair dealing, and other violations of his rights in the same or similar manner as others in the class (see for example **Exhibits 1-61);** and

j) Is entitled to recovery, including interest from the date of payment, attorney fees,

[25] Some class members, such as beneficiaries and successors in interest, did not themselves sign the form contract, but their rights arise from the principal who signed the form contract.

and other relief that would make whole (see for example **Exhibits 1-61**).

V. Class Definition

196. Plaintiffs' bring this action, on behalf of themselves and all others similarly situated, as a class action pursuant to section 382 of the *California Code of Civil Procedure*. The class which Plaintiffs seek to represent is compose of and defined as follows:

> All persons (and their beneficiaries or successors in interest) who were enrolled in PPO health insurance coverage offered by CalPERS/Anthem (including PersCare, PERSChoice, PERSSelect, et al) where CalPERS and/or Anthem reimbursed "out-of-network" "medical expenses" (including medical services, fees, tests, labs, procedures, equipment, treatments, surgery, exams, costs, charges, or other expenses) at a rate less than the reasonable or appropriate industry standard.

197. The class includes those described above who seek damages for breach of contract, breach of CalPERS' various fiduciary duties, or the other causes of action listed in this Complaint.

198. "Medical expenses" include the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body.

199. The class includes those who seek proper reimbursement of "out-of-network" "medical expenses" that were accepted but not properly reimbursed by Anthem and/or CalPERS under a PPO plan including but not limited to those related to physician visits, professional fees, facility fees, charges, tests, labs, procedures, equipment, treatments, surgery, exams, and other "out-of-network" "medical expenses".

200. The class includes those described above who seek interest on damages or the reduced reimbursement funds from the date of the claim was under-reimbursed until properly paid.

201. Plaintiff reserves the right including under Rule 3.765 (formerly 1855(b), *California Rules of Court*, to amend or modify the class description with greater specificity or further division into subclasses or limitation to particular issues.

202. **Class Period.** The Class Period starts when the first individual bought health or

medical coverage that provided reimbursement for PPO and non-PPO medical expenses with Anthem or with CalPERS and continues until the most recent period. At the least, the class period starts for those who contracted or enrolled in PPO insurance starting or between January 1, 2006 and continues through December 31, 2014.

203. **Tolling.** Heinz has been actively and diligently pursuing recourse in the Anthem and CalPERS administrative processes, as required by Anthem and CalPERS, since 2008. **Exhibit 1-25, 54**. Heinz was required to wait to pursue civil legal remedies until after exhausting administrative review and an administrative hearing. See 2CCR § 599.518. All individual and representative claims are tolled during this period.

204. **Delayed Accrual, Fiduciary Context.** See *infra*.

LEGAL BASIS OF CLAIMS

205. **The Knox-Keene Act.** CalPERS and Anthem plans offered by CalPERS/Anthem (including PersCare, PERSChoice, PERSSelect, et al) are health care service plans. As such, the CalPERS and Anthem plans may be governed by in part the comprehensive system of licensing and regulation known as the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). (*Health & Saf.Code,* § 1340 et seq.; *Prospec Medical Group, Inc. v. Northridge Emergency Medical Group* (2009)45 Cal.4th 497, 504.)

206. **Law of Reasonable Reimbursements, Knox Keene Act.** The Department of Managed Health Care (DMHC) is charged with the administration and enforcement of the laws relating to health care service plans. (*Health & Saf. Code*, §1341.) To carry out its duties, the DMHC is authorized to promulgate regulations. (*Health & Saf.Code,* §1344; *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1271–73.)

207. Although applicable directly only to emergency services, section 1300.71 of title 28 of California Code of Regulations is titled "Claims Settlement Practices" should apply to clarify the "Allowable Amount" definition and the reimbursements. This regulation is authorized by Health and Safety Code sections 1371 and 1371.35. These statutes impose procedural requirements on claim processing and subject health care service plans to disciplinary action and penalties for failure to timely comply with those requirements. (*California Medical Assn. v.*

Aetna U.S. Healthcare of California, Inc. (2001) 94 Cal.App.4th 151, 163.)

208. The DMHC explained in its initial statement of reasons that California Code of Regulations, title 28, section 1300.71 was "necessary to clearly define terms relating to claim settlement and reimbursement, and provide procedures for plans and providers to prevent unreasonable delays in payment of provider claims." Further, the DMHC wanted to clarify "the meaning of unfair payment practices and the term 'complete and accurate claim.' "

209. In this case, CalPERS' and Anthem's EOC terms are not clearly defined, especially in the third subpart of the "Allowable Amount" definition. In order to incorporate standards and clarity that are required as a matter of public policy, the standards in section 1300.71(a)(3)(B) should also be applied to "Allowable Amount" and reimbursement terms for the non-emergency, out-of-network medical services in this case. Section 1300.71 would give clear meaning and consistency to the three subparts of the "Allowable Amount" definition in the PPO policy. Section 1300.71 is consistent with the first and second part of the "Allowable Amount" definition, and would provide needed standards for the third part of the definition, especially as the examples are consistent with the terms in regulation 1300.71.

210. As outlined above, section 1300.71(a)(3)(B) defines " 'Reimbursement of a Claim' " for noncontracted providers. Such reimbursement means "the payment of the reasonable and customary value for the health care services rendered." The reasonable and customary value is to be "based upon statistically credible information that is updated at least annually" and takes six factors into consideration. These factors are: "(i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." (§1300.71(a)(3)(B).)

211. In responding to comments, the DMHC refused to specifically set reimbursement amounts. For example, the DMHC rejected suggestions that noncontracted providers should either be reimbursed at 100 percent of their billed charges or be reimbursed based on Medicare or Medicaid fee schedules. Rather, the DMHC explained that California law requires payors to

reimburse noncontracted providers based upon the reasonable and customary value of the services rendered.

212. The DMHC further noted that the "regulations are intended to set forth the *minimum* payment criteria to ensure compliance with the [Knox-Keene] Act's claims payment and dispute resolution standards" (italics added), and that, to the extent providers wish to pursue other common law or statutory remedies, they may seek redress in the courts. According to the DMHC, this regulation accurately reflects California law and incorporates the concept of quantum meruit.

213. In the final statement of reasons for California Code of Regulations, title 28, section 1300.71, the DMHC explained that the intent was to establish a methodology for determining the reasonable value of health care services by noncontracted providers but that the criteria specified do not dictate a specific payment rate. Rather, the payor is required to calculate the appropriate reimbursement based on statistically credible information that takes the *Gould* factors into consideration. If a payor fulfills its claims payment obligation using these criteria, the DMHC will consider the payor compliant with Health and Safety Code sections 1371 and 1371.35, i.e., the reimbursement of the claim will be deemed timely. "However, the definition is not a substitute for traditional forums for contract dispute resolution. If a provider disputes the payor's calculation of the fair and reasonable value of the health care services he has rendered, the provider is free to seek resolution of that dispute in a court of law or through any other available civil remedy."

214. In sum, in adopting section 1300.71(a)(3)(B), the DMHC established the minimum criteria for reimbursement of a claim, not the exclusive criteria. *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1271–73 [172 Cal.Rptr.3d 861, 870–71].

215. Since the third subpart of the "Allowable Amount" definition in the EOC is inherently ambiguous and unclear, the court should use Section 1300.71 to establish a minimum criteria for reimbursement.

PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT ("PEMHCA")

I. PEMCHA

216. CalPERS statutory obligations regarding health benefits are governed in part by Public Employees' Medical and Hospital Care Act ("PEMHCA"), Gov. Code, §§ 22750 to 22944.3 and include:

a) The board shall make available to employees and annuitants eligible to enroll in a health benefit plan information that will enable the employees or annuitants to exercise an informed choice among the available health benefit plans. Each employee or annuitant enrolled in a health benefit plan shall be issued an appropriate document setting forth or summarizing the services or benefits to which the employee, annuitant, or family members are entitled to thereunder, the procedure for obtaining benefits, and the principal provisions of the health benefit plan. *Government Code*, §22863.

b) CalPERS regulations require the payment schedule for such benefits must be sufficient in the judgment of the Board to meet the major share of usual, customary, or reasonable charges for such services. 2 CCR §599.510.[26]

c) Each contract shall contain a detailed statement of benefits offered and shall include maximums, limitations, exclusions, and other definitions of benefits as the board deems necessary or desirable. *Government Code*, §22853.

217. PEMCHA incorporates prevailing practices in the medical community. *Government Code*, §22796 requires that the CalPERS board shall adopt all necessary rules and regulations to establish reasonable minimum standards for health benefit plans that are consistent with prevailing practices in the field of medical and hospital care. *Government Code*, §22796.

218. *Government Code*, §22859(a) A health benefit plan or contract may not provide any of the following: (1) An exception for other coverage where the other coverage is entitlement to Medi-Cal or medicaid benefits. (2) An exception for Medi-Cal or medicaid

[26] Determination of usual, customary, and reasonable charges for purposes of this subsection 599.510(a) shall take into account the Relative Value Studies of the California Medical Association with respect to any service included in such Studies.

benefits. (3) A benefits reduction if the person has entitlement to Medi-Cal or medicaid benefits.

219. Premiums charged for enrollment in a health benefit plan shall reasonably reflect the cost of the benefits provided. *Government Code*, §22864.

220. Information disseminated by the board pursuant to Section 22863, and compliance with regulations of the board adopted pursuant to subdivision (a) of Section 22846 and Sections 22800 and 22831, shall be deemed to satisfy the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the *Health and Safety Code. Government Code*, §22869 (i.e. Knox Keene Act). Section 22863 is addressed to information requirements, and Section 22846, 22800 and 22831 address enrollment issues. These do not address the reasonableness of standards for reimbursement or California Code of Regulations, title 28, section 1300.71, or the minimum reimbursements.

221. Therefore, although PEMHCA sections §§22869, *et seq.* purport to satisfy the requirement of several provision of the Knox-Keene Health Care Service Plan Act, the specific "satisfied" sections in PEMCHA do not address the reasonable value of reimbursement, including (i) *Government Code* §22796, (ii) California Code of Regulations, title 28, section 1300.71 and (iii) 2 CCR §599.510.

222. 2 CCR §599.510 is based in *Government Code* Sections 22794 and 22796, and reference *Government Code* Sections 22796, 22850, 22853 and 22860 which do not involve reasonable reimbursements.

223. Therefore, the sections of the Knox Keene Act about the reasonableness of the reimbursement addressed above still apply. The reasonableness of the reimbursement requirement of the Knox Keene Act is not deemed satisfied.

224. In addition, PEMHCA does not supersede, modify, or in any manner alter or impair the effect of any provision of Chapter 5 (commencing with Section 2000) of Division 2 of the *Business and Professions Code* or any provision of the *Insurance Code*. PEMCHA shall be interpreted and applied in a manner consistent with those provisions of the *Business and Professions Code* and the *Insurance Code*. *Government Code*, §22867.

225. Under 2 *CCR*, § 599.510. Minimum Scope and Content of Basic Health Benefits

Plans:

(a) No contract shall be made or approved for a basic health benefits plan which does not include in its coverage the following benefits. **The payment schedule for such benefits must be sufficient in the judgment of the Board to meet the major share of usual, customary or reasonable charges for such services.**

Hospital benefits.

In-hospital.

Coverage must be extended to enrolled employees, annuitants, and family members to provide benefits in the event of confinement in a hospital because of injury or sickness.

Hospital "room and board benefits" must be provided for at least the first 31 days of hospital confinement. "Miscellaneous hospital benefits" must be provided for hospital charges incurred over and above those for room and board, such as charges for the use of operating and cystoscopic rooms, anesthetic supplies, anesthesia when supplied by the hospital as a regular service and administered by a salaried employee, ordinary splints, plaster casts, and surgical dressings.

(B) Outpatient -hospital.

Coverage must be extended to enrolled employees, annuitants, and family members to provide benefits because of accidental bodily injury, surgery or emergency treatment for sickness when not admitted to a hospital or confined as a registered bed patient. Such benefits shall include but are not limited to: 1. Charges for use of operating and cystoscopic rooms, 2. Charges for anesthetic supplies and anesthesia when supplied by the hospital as a regular service and administered by a salaried employee, and 3. Charges for ordinary splints, plaster casts and surgical dressings.

(2) Surgical Benefits In and Out of the Hospital.

Coverage must be extended to enrolled employees, annuitants and family members to provide benefits in the event of surgical operations performed because of injury or sickness.

In-hospital medical benefits.

Coverage must be extended to enrolled employees, annuitants, and family members to provide benefits for medical services rendered by attending physicians or physician anesthetists, other than those of a surgeon as described above, while a registered bed patient in a hospital.

Outpatient medical benefits.

Coverage must be extended to enrolled employees, annuitants and family members to provide benefits for medical services rendered on an outpatient basis. Such services shall include those of a physician and surgeon for usual medical services and a physician anesthetist.

Diagnostic, X-ray, and laboratory examinations benefits in and out of the hospital.

Coverage must be extended to enrolled employees, annuitants, and family members and shall include those services of medical and paramedical personnel such as, but not restricted to, a pathologist, or a roentgenologist to provide for all ordinary clinical and pathological laboratory services and X-ray examinations.

Such services may be rendered either by physicians or by salaried hospital or clinical personnel as appropriate.
Maternity benefits. Coverage must be extended to each enrolled employee, annuitant, and covered family member to provide medical and hospital benefits for maternity care.
Ambulance service benefits. Coverage must be extended to enrolled employees, annuitants, and family members to provide benefits for necessary local professional ambulance service to a hospital.
Determination of usual, customary, and reasonable charges for purposes of this subsection 599.510(a) shall take into account the Relative Value Studies of the California Medical Association with respect to any service included in such Studies. (*emphasis added*)[27]
(b) There shall be excluded from coverage set forth above:
charges incurred in connection with bodily injury or disease covered by worker's compensation statutes or similar legislation.
charges for which the claimant has been or is entitled to be reimbursed under any other basic hospital, surgical or medical plan not subject to these rules for which the employer shall have paid any part of the costs. Premiums or other consideration paid for the coverage not provided shall be returned to the person, state agency or contracting agency equitably entitled thereto.
charges incurred during confinement in a hospital owned or operated by the United States Government, charges for services, treatments or supplies furnished by or for the United States Government or paid for by said United States Government, or charges incurred during confinement in a hospital owned or operated by a state, province, or political subdivision, unless there is an unconditional requirement to pay these charges without regard to any rights against others, contractual or otherwise.
services and charges for services for which the claimant is entitled to have payment made on his or her behalf under Part A or Part B, Title XVIII of the Social Security Act.
charges in accordance with such other exclusions as may be agreed to by the Board.
(c) There may be excluded from coverage set forth above:
charges incurred by or on behalf of a family member or services received by a family member during a continuous period of hospitalization which commenced before the effective date of the enrollment if eligibility to enroll including him or her in coverage of a plan derives from other than an open enrollment period; and
charges incurred or services received by an employee, annuitant, or family member during a continuous period of hospitalization which commenced before the effective date of his or her enrollment if eligibility to enroll derives from an open enrollment period. Such exclusion shall no longer apply upon the 91st day of enrollment in the plan.

226. Other PEMHCA sections also apply.

[27] Although the CMA no longer publishes Relative Value Studies, the legislation reflects the public policy that reimbursement would be at the UCR rates in the location.

II. CalPERS' and Anthem's Breach of PEMHCA and Knox Keene Act

227. CalPERS and/or Anthem breached PEMHCA, including *Government Code* sections 22863, 22853, and 22864, including by failing to disclose the terms of the reduced "Allowable Amount," by using reduced inappropriate "Allowable Amounts", and failing to pay reasonable reimbursements.

228. CalPERS and/or Anthem breached the Knox Keene Act, including by failing to disclose the terms of the reduced "Allowable Amount," by using reduced "Allowable Amounts", failing to use UCR rates, and failing to pay reasonable reimbursements.

229. CalPERS and/or Anthem breached the regulations and statutes that require the use of usual, customary, and reasonable reimbursements.

230. CalPERS' and Anthem's reimbursement policies and practices also violate the applicable standards in the regulations, in (i) Cal. Code Regs., tit. 28, 1300 et seq, (ii) 2 CCR 500 et seq, including section 599.510, and (iii) section 1300.71 of title 28 of California Code of Regulations (which should be applied here in the nonemergency out-of-network contest because the terms in the EOC are otherwise so vague and without standards as to be illusory).

A. Reimbursement of Claims Amount Set Forth in EOC Cal. Code Regs., tit. 28, § 1300.71

> (3) "Reimbursement of a Claim" means:
> (A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;
> (B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and
> (C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.
> (Cal. Code Regs., tit. 28, § 1300.71.)

231. Anthem and CalPERS argue that only subpart C applies directly because these are non-emergency services, but CalPERS and Anthem ignore that the amount set forth in the enrollees' Evidence of Coverage is otherwise without standards. Without standards, CalPERS and Anthem's greatly reduced reimbursement fails under subsection (c) because that subsection cannot be administered consistently with the other terms and examples in the EOC.

232. In addition, the amount set forth in the EOC examples indicate that it would be an identical "Allowable Amount" whether in plan or out-of-network.

233. Anthem and CalPERS seek to apply only subsection (a)(3)(C) of reg 1300.71, and then point to the third subpart of the "Allowable Amount" to indicate that that one vague portion of the EOC gives them unfettered discretion to reduce the "Allowable Amount," contrary to the more specific representations and terms in the EOC that the "Allowable Amount" will be identical whether in plan or out of plan.

234. However, the examples and the other subparts provide guidance, including as the third subpart and the overall definition of "Allowable Amount" in the context of all of the EOC is so ambiguous, contradictory, and unclear. For example under Subpart A, Dr. Walker was a contracted provider immediately prior to going NPP. However, CalPERS did not use the contracted rate in the "Allowable Amount" definition or reimburse Heinz at the prior agreed upon contract rate or anything close to it.

235. For example, under subpart B, CalPERS and Anthem failed to use the second subpart of the "Allowable Amount" definition and did not use the usual, customary, and reasonable rate for the health care services.

236. Under subpart C, CalPERS and Anthem failed to reimburse Heinz at the amount set forth in the enrollee's Evidence of Coverage. In the examples in the EOC, the "amount set forth in the enrollee's Evidence of Coverage" for the "Allowable Amount" indicates that the "Allowable Amount" should be identical for in-network as "out-of-network" providers.

CONTRACT AND TERMS OF THE EOC

I. Contract Terms Are Not Clear: The Contract Says that the "Allowable Amount" for In-Plan Will Be the Same as the "Allowable Amount" Out-of-Plan

237. CalPERS and Anthem greatly reduced "Allowable Amount," unreasonably low reimbursement, inadequate disclosure, and other acts or omissions breaches the contract(s).

238. The three-part definition of "Allowable Amount" does not clearly provide for the reimbursements that are substantially lower than appropriate usual, customary, or reasonable (UCR) amounts.[28]

239. **Issues About Contract Terms.** In this case, the examples in the EOC/contract demonstrate that the calculation of the "Allowable Amount" will result in an identical "Allowable Amount" for in- network or "out-of-network" medical services. See **Exhibits 24-26, 28, 41-53** and examples above at paragraphs 1 - 150

240. The contract terms about the parity of the "Allowable Amount" are express and clear.

241. Both CalPERS and Anthem fail to disclose that the ***single biggest detriment*** involved in buying a PPO plan and then "going out-of-network" is the greatly reduced calculation of the "Allowable Amount."

242. Instead, the contracts purport to indicate the major difference in going "out-of-network" was that the deductible is raised to 40 percent from 20 percent. The increase in deductible is a clearly drafted provision. The clear and patent increase in the copay from 20 percent to 40 percent is sufficiently large and clear to indicate that increased copay is the only cost of going out-of-network.

243. No information is provided about a changed or reduced "Allowable Amount" for out-of-network medical services.

244. Participants are entitled to clear examples and clear disclosure. Participants are entitled to expect similarly clear language and "appropriate" examples concerning the lowering

[28] CalPERS and Anthem relied on *Orthopedic Specialists* in the administrative process. It is not on point and irrelevant. In *Orthopedics Specialists, the out of network doctors* directly sought UCR recovery from CalPERS. The *doctors* were not in privity of contract with CalPERS or Anthem. No fiduciary duties applied. The court ruled in contradictory *dicta* about the contract terms (which could not apply as it held that there was no contract) that "just because an NPP believes that the EOC's provisions are unfair does not mean the provisions can be ignored or that they are unenforceable. The contract says what it says." (*Orthopedic Specialists, supra*, at 648.)

of Allowable Amounts too.

245. Instead, CalPERS and Anthem provide utterly misleading and erroneous examples about the most important variable involved: the calculation of the "Allowable Amount."

246. Under the EOC's terms, each of these subparts of the "Allowable Amount" definition should provide a similar or identical "Allowable Amount." There is no disclosure that one part of the Definition would provide a significantly reduced calculation of the "Allowable Amount."

247. The third subpart of the "Allowable Amount" definition if not interpreted consistent with the first two subparts is so vague, unilateral, and self-serving, and so lacking in benchmarking or other guidance, that it fails to give notice and is not an agreed upon term in the EOC. Allowing the third subpart to provide unreasonably low and arbitrary reimbursement rates would override the UCR standards and render the EOC an illusory contract.

248. At a minimum, but without limitation, the third subpart cannot stand without incorporating objective standards consistent with appropriate industry standards. The third subpart must be administered consistent with a reasonableness rule so that by its own terms it does not produce arbitrary or capricious results.

249. Indeed, a reimbursement rate that is not based on value of the service relative to the value of other services, market considerations, and provider charge patterns, the agreed upon rate, and other usual, customary, and reasonable rates could not be "appropriate."

PLAINTIFFS' CLAIMS: BREACH OF CONTRACT CLAIMS

I. Breach of Contract

250. CalPERS and Anthem breached their contractual duties to Heinz and other proposed class members, including under the plan documents, as CalPERS and/or Anthem failed to pay or cause Anthem to calculate "Allowable Amounts" that are usual reasonable and customary, including that were the same or similar for PPO as for non-PPO providers.

251. Heinz and the class performed all aspects of their duties.

252. Heinz and the class prove (1) the existence of PPO contract, (2) Plaintiff's performed all their required terms of the PPO contract when they submitted the claims for reimbursement and the claims were accepted for reimbursement, albeit at an improperly low rate, (3) CalPERS' and Anthem's breach of the PPO contract by providing inappropriately low reimbursement, including that is inconsistent with the terms of the EOC and (4) that CalPERS' and Anthem's improperly reduced reimbursement and "Allowable Amounts" caused resulting damage to the Plaintiff and the class members. (*Richman v. Hartley* (2014) 224 Cal.App.4th 1182, 1186.)

253. Heinz has shown that CalPERS' and Anthem's breach caused the Plaintiff's damage. (*Troyk v. Farmers Group, Inc.* (2009) 171 Cal.App.4th 1305, 1352.)

254. Heinz (and the class) has proven he (and the class) has performed all conditions on its part or that it when he submitted the claims to Anthem and Anthem accepted the claims, albeit for improperly low reimbursements, and then Heinz individually and on behalf of a class challenged the reimbursement in both Anthem's and CalPERS' administrative process, to a final conclusion. Only one class representative needs to exhaust the administrative process. All of the class members also have or will have presented claims to Anthem and/or CalPERS and had the claims accepted, however Anthem and/or CalPERS paid each class member based on a reduced "Allowable Amount" and paid a reduced reimbursement rate. Heinz has shown that after the claims are presented to CalPERS and Anthem, then CalPERS and Anthem's duty to perform the reasonable reimbursement under the contract occurred, yet CalPERS and Anthem breached their duty by failing to pay proper reimbursements. Heinz and the class's claims have occurred or accrued with the presentation of the claims to Anthem and CalPERS and all other events conditioned on the reimbursement, have transpired. (*Consolidated World Investments, Inc., v. Lido Preferred Ltd.* (1992) 9 Cal.App.4th 373, 380.)

255. CalPERS' and Anthem's wrongful, i.e., the unjustified or unexcused, failure to perform a contract is a *breach*. The nonperformance is not legally justified, and not excused.

256. Heinz and the class will prove all of the following:

a) That each Plaintiff and CalPERS and Anthem entered into a contract;

b) That each Plaintiff did all, or substantially all, of the significant things that the contract required him/her/it to do;

c) That each Plaintiff submitted a valid claim for reimbursement that CalPERS and/or Anthem accepted and reimbursed, albeit at a reduced rate;

d) That CalPERS and Anthem failed to do something that the contract required when CalPERS and Anthem failed to reimburse properly and failed to calculate the "Allowable Amount" at the correct rate;

e) That CalPERS and Anthem did something that the contract prohibited him/her/it from doing when they failed to provide reimbursement at the reasonable rates, including failing to provide reimbursement and "Allowable Amounts" at the rates reflected in the examples in the EOC;

f) That each Plaintiff was harmed; and

g) That CalPERS' and Anthem's breach of contract was a substantial factor in causing each Plaintiff's harm.

II. <u>Health Plans, Insurance Contracts, Breach of Contract</u>

257. While health plans and insurance contracts have special features, they are still contracts governed by the ordinary rules of contract interpretation. (*Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1264; *Van Ness v. Blue Cross of California, supra,* 87 Cal.App.4th at p. 372.) "The fundamental goal of contractual interpretation is to give effect to the mutual intention of the parties. [Citation.] If contractual language is clear and explicit, it governs. [Citation.] On the other hand, '[i]f the terms of a promise are in any respect ambiguous or uncertain, it must be interpreted in the sense in which the promisor believed, at the time of making it, that the promisee understood it.' [Citations.] This rule, as applied to a promise of coverage in an insurance policy, protects not the subjective beliefs of the insurer but, rather, 'the objectively reasonable expectations of the insured.' [Citation.] Only if this rule does not resolve the ambiguity do we then resolve it against the insurer. [Citation.] In summary, a court that is faced with an argument for coverage based on assertedly ambiguous policy language must first attempt to determine whether coverage is consistent with the insured's objectively reasonable

expectations. In so doing, the court must interpret the language in context, with regard to its intended function in the policy. [Citation.] This is because '*language in a contract* must be construed in the context of that instrument as a whole, and in the circumstances of that case, and *cannot be found to be ambiguous in the abstract.*' [Citations.]" (*Bank of the West v. Superior Court, supra,* at 1264-1265, emphasis in original.)

258. The "objectively reasonable expectations" of insureds means interpretation in the sense that an insurance company could reasonably believe an insured, as a layperson, not an expert, would understand the terms, and not the subjective beliefs of either the insurance company or a particular insured. If these first two steps are both necessary and do not resolve interpretation of the meaning of the terms, the terms are deemed ambiguous and, as between alternative reasonable meanings, must be construed against the insurer (draftsman) and in favor of the insured. Finally, even if the terms are unambiguous, if the effect of the terms is to limit or exclude coverage, the terms are reviewed under a strict scrutiny standard and must be set forth clearly and conspicuously in the contract in order to be enforceable. (*Montrose Chemical Corp. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, 667; *La Jolla Beach and Tennis Club, Inc. v. Industrial Indemnity Co.* (1994) 9 Cal.4th 27, 38; *Bank of the West v. Superior Court (1992)* 2 Cal.4th 1254, 1264; *AIU Ins. Co. v. Superior Court* (1990) 51 Cal.3d 807, 821-822; *Civil Code* §§1638, 1639, 1654; *Ponder v. Blue Cross of Southern California* (1983) 145 Cal.App.3d 709, 718.)

259. The same rules applicable to insurance contracts are applicable to interpretation of health service plans, even if health service plans are technically different than insurance policies in terms of regulatory authority, the former being regulated by the Department of Insurance and the latter being regulated formerly by the Department of Corporations and now by the new Department of Managed Care. (*Warren-Guthrie v. Health Net* (2000) 84 Cal. App. 4th 804, 814 [California courts construe health plans "as they would an insurance policy.... As such, they are interpreted in the first instance by the rules of construction applicable to contracts."]; *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 3 (fn 1), 13 [for purposes of discerning the duties and obligations under insurance contracts and health service plans there is no legal distinction

between the two; any doubts respecting coverage must be resolved in favor of the insured or subscriber].[29]

260. The rule requiring interpretation of health service plan contracts in favor of coverage applies even if the plan was negotiated on a group basis and is not determined to be a contract of adhesion. See *Sarchett v. Blue Shield of California, supra* at 3, fn.1, 13, fn. 14.

261. **EOC cannot limit expected coverage.** An evidence of coverage or summary of benefits cannot diminish a contract benefit. The law specifically governing health service plans provides that an evidence of coverage cannot be used to reduce or unfavorably limit a contract benefit of a plan member.

262. An "evidence of coverage" includes any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth coverage to which the subscriber or enrollee is entitled. (*Health & Safety Code* §1345(d).)

263. In other words, the wording of an evidence of coverage can favorably expand coverage for a subscriber or plan member, but not restrict it. (See also *Bareno v. Employers Life Ins. Co. of Wausau* (1972) 7 Cal.3d 875, 881-82 [insurer bound by broader coverage in evidence of coverage].)

264. Where two constructions[30] of the insurance policy are deemed reasonable, that

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[29] In addition, see *Washington Physicians' Service Assn. v. Gregoire, 147 F.3d 1039, 1045-1046 (9th Cir. 1998), cert. denied 525 U.S. 1141, 119 S.Ct. 1033 (1999),* holding that health service plans are indistinguishable from insurance policies for purposes of ERISA preemption analysis under ERISA's insurance savings clause applicable to the business of insurance. Likewise, *California Civil Code §3428,* in its legislative findings and declaration of intent, states that health care service plans are engaged in the business of insurance as that term is used under the McCarran-Ferguson Act even though California, for regulatory purposes, has chosen to regulate insurers and health care service plans under different regulatory agencies.

[30] If a plan term is capable of two constructions, both reasonable, it is ambiguous. (*La Jolla Beach and Tennis Club, etc., supra* at 38.) The general rule is that if coverage is available under any reasonable interpretation of an ambiguous clause of an insurance policy or plan, the insurer cannot escape its obligation to provide benefits. (*20th Century Insurance Co. v. Liberty Mutual Ins. Co.*, 965 F.2d 747, 751 (9th Cir. 1992, citing with approval *Ponder v. Blue Cross of Southern California, supra* at 718 [a policy term that would operate as a limitation on, or exclusion of, a benefit is subject to strict scrutiny], and *Employers' Reinsurance Corp. v. Phoenix Insurance Co.* (1986) 186 Cal.App.3d 545, 554; *Chamberlin v. Smith* (1977) 72 Cal.App.3d 835, 844-45.)

which is more favorable to the insured is to be adopted. (*Schilk v. Benefit Trust Life Insurance Company* (1969) 273 Cal.App.2d 302, citing *Tavares v. Glen Falls Ins. Co.* (1956) 143 Cal.App.2d 755, 761 [that insurance clause which affords the most protection to the insured will control and be given effect]; *Frenzer v. Mutual Ben. H. & A. Assn. (1938) 27 Cal.App.2d 406, 415-416.*)

265. Nowhere in any of the promotional material, the forms, or the contract does it state that CalPERS or Anthem are affirmatively renouncing the customary reimbursement standards such as UCR in favor of a much less favorable one to the insureds. **Exhibits** 46-53, 55. Moreover, subpart 3 of the "Allowable Amount" definition is so vague and purports to confer so much discretion that it cannot be permitted to survive unless reasonableness and reasonable particular terms are read into the provision as a matter of law.[31]

266. The contra-insurer rule is supported by public policy strongly articulated by the California Supreme Court; it is incumbent upon the insurer-draftsman to write policies or plans with precision and administer them so as to avoid confusion; insurers and health service plans cannot look to the court to rescue them from their own uncertain terminology. (*Bareno v. Employers Life Ins. Co. of Wausau, supra* at 875; see also *Humphrey v. Equitable Life Assur. Soc., supra* at 534 [insurer who drafts the insuring instrument in language it selects cannot thereafter complain that it does not express the intention of the parties].) Even if it is assumed, *arguendo*, that such an alternative meaning does not add to or contradict the plain meaning of the terms of the deductible provisions in the policy, but rather is a reasonable alternative, it would be an alternative meaning suggested by the insurer-draftsman of the form contract that is less favorable to the insured.

267. Again, to the extent that the third subpart of the "Allowable Amount" definition provides grounds for the much lower and unreasonable reimbursements via greatly reducing the "Allowable Amount" (and there does not appear to be any other ground for the much lower

[31] Indeed, if it is allowed to remain part of the EOC without sufficient standards and benchmarks, the contract itself may be treated as void *ab initio*, for vagueness and lack of performance standards such that there is no authority for providing any reimbursement other than using the standards providing for adequate reimbursement such as UCR. See supra.

reimbursement), then the third subpart (or other relevant part of the contract) violates public policy, and must be voided or interpreted in a manner that provides reasonable reimbursements to participants.

268. **Materiality of insurer misrepresentations to policyholder.** Misrepresentations by the insurer to the policyholder are deemed material (hence, a defense to enforcement of the contract) "if they would have substantially influenced the selection process by person choosing the plan." (*Engalla v. Permanente Med. Group, Inc.*, supra, 15 C4th at 977-978, 64 CR2d at 860.)

269. CalPERS represented that it was offering PPO insurance, the EOC in fact represented that the "Allowable Amount" was the same for in plan as out of plan members, etc.

270. All of these representations are material.

271. **Limits on amount of benefits.** Health insurance policies often impose limits on the amount the insurer will pay for any single covered benefit.

272. When the exclusionary terms in the contract are clear, conspicuous, and unambiguous, then the contract can effect exclusions. To avoid any uncertainty as to what is "reasonable and necessary," insurers may modify their policies to include clear and conspicuous exclusions for particular types of treatment or illnesses. (Example: "This insurance does not cover ... any drug, treatment, procedure, or therapy not previously approved by the Federal Drug Administration.") (See *McLaughlin v. Connecticut Gen. Life Ins. Co.*, supra, 565 F.Supp. at 437.)

273. As some examples: (1) some health insurance policies contain schedules showing a *fixed or maximum amount* payable for each medical treatment, hospital service, etc. (2) Others obligate the insurer to pay all or a percentage of "*reasonable and necessary*" or "*usual and customary*" expenses (see below). (3) Still others express a *formula* for determining benefits. Such formulas are valid if reasonably clear. (See *Van Ness v. Blue Cross of Calif.* (2001) 87 CA4th 364, 375, 104 CR2d 511, 518, fn. 4—for services rendered by "non-network" medical provider, benefits limited to 70% of a "limited fee schedule" derived by multiplying the "relative value schedule" unit value for the service by the appropriate unit allowance for the particular service area; formula sufficiently clear.)

274. In this case, there were no clear, patent, or unambiguous exclusionary terms concerning the reduced "Allowable Amount." At best, the terms were misrepresented and unclear.

275. **Definitions Excluding Coverage and Exclusion Are Interpreted Against Insurer.** As with other exclusions and limitations, definitions that create exclusions are strictly construed against the insurer and in favor of the insured. But if the exclusion is plain, clear and conspicuous, it will be given effect. (*Mogil v. California Physicians Corp.*, supra, 218 CA3d at 1036.)

III. Insurance Contracts, Exclusions Must Be Clear

276. Finally, even if the terms are unambiguous, if the effect of the terms is to limit or exclude coverage, the terms are reviewed under a strict scrutiny standard and must be set forth clearly and conspicuously in the contract in order to be enforceable. (*Montrose Chemical Corp. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, 667; *La Jolla Beach and Tennis Club, Inc. v. Industrial Indemnity Co.* (1994) 9 Cal.4th 27, 38; *Bank of the West v. Superior Court (1992)* 2 Cal.4th 1254, 1264; *AIU Ins. Co. v. Superior Court* (1990) 51 Cal.3d 807, 821-822; *Civil Code* §§1638, 1639, 1654; *Ponder v. Blue Cross of Southern California* (1983) 145 Cal.App.3d 709, 718.)

277. **"Usual, customary and reasonable" UCR case law in Quantum Meruit Context.** There are few California cases dealing with "usual, customary, and reasonable" rates outside the quantum meruit context.

278. In *Children's Hospital Central California v. Blue Cross of California* (2014), the court referred to the Department of Managed Health Care (DMHC) that has set the standards for minimum reimbursement, including reasonable and customary value in section 1300.71(a)(3)(B). *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1267–68.

279. In the quantum meruit case law, the doctors are suing the health insurer for providing (typically) emergency services as out-of-network providers. No contract exists between the doctors and the health plan. No contract terms apply.

280. Recently the Second District referred to *Children's Hospital* but found that other data than historical records of medical services actually paid can be used to determine the usual, customary, and reasonable rate. See *Goel v. Regal Medical Group, Inc.* (Cal. Ct. App., May 23, 2017, No. B267012) 2017 WL 2242981, at *5.

281. The Second District ruled that the holding in *Children's Hospital* did not limit the evidence relevant to the reasonable value of medical services to any single factor, but rather confirmed that, consistent with the law on quantum meruit, any evidence bearing upon the "reasonable market value" of such services is relevant. (*Ibid.*)

282. Generally, courts are likely to side with insureds as to what fees are "usual and customary" in order not to interfere with the insureds' access to physicians of their choice. Nor are courts likely to sympathize with insurer objections to the amount of fees after an insured has already incurred the debt without notice from the insurance company as to what lesser amounts would be accepted as "usual, customary, and reasonable."

283. **Lack of good faith.** CalPERS and Anthem contracted directly with Heinz and others for "PPO" coverage, based on written standardized promotional materials, the EOC (which is imposed unilaterally and not made available before a participant chooses a plan), and other agreements made in writing in the course of administering the plans and interacting with participants, when, for example, and as here and not in good faith:

- When CalPERS/Anthem represents in writing it will pay a certain amount and then fails to do so;
- When CalPERS/Anthem arbitrarily and capriciously reduces the reimbursement on the pretext of causing or *interpreting* one part of a definition in a unfair, undisclosed, and inexplicably volatile manner;
- When CalPERS/Anthem fails to interpret the definition of "Allowable Amount" in a consistent fashion, contrary to its representations, and without notice lowers a member's reimbursement for the same or similar services,;

Again, the exact nature of some of these individual facts is not necessary to seek the remedies plaintiff requests the Court to make, but they represent how CalPERS does not itself view the

EOC and other contracts as clear and unambiguous. Instead, CalPERS/Anthem use imprecise and ambiguous terms to impose exclusions, restrictions and exceptions to coverage that they apply after the fact in secret. Plaintiff Heinz, *in fact*, only at the CalPERS administrative hearing came to understand CalPERS and Anthem apparently never intended for "appropriate" or "Allowable Amount" to actually provide standard reimbursements.

IV. Parole Evidence Rule

284. First, the plain meaning of the terms is evident. Second, no objective reasonable insured would understand the terms to mean that the "Allowable Amount" would be something lesser than and very different from the equivalent to the "Allowable Amount" of those in-network. Third, neither CalPERS' nor Anthem's later interpretation should vary or contradict the plain meaning of contract terms. Fourth, CalPERS' and Anthem's attempt to change the meaning of "Allowable Amount" by referring only to the third subpart is inadmissible. Fifth, the suggested plain meaning of the "Allowable Amount" as equivalent for PPO and non-PPO services is reasonable. The only purpose to be served by introducing extrinsic evidence which is not part of a fully integrated contract would be to create an alternative meaning or interpretation contradicting the plain language or rendering the terms ambiguous.

285. **Anthem's Breach of Regulations 2 *CCR*, §599.508.** Minimum Standards for Health Benefits Plans. Anthem breaches 2 *CCR*, §599.508 (a) To be qualified to be approved or adopted by the Board, a health benefits plan must:(1) Comply with the Public Employees' Medical and Hospital Care Act and this subchapter, as amended from time to time.

BREACH OF FIDUCIARY DUTIES

I. CalPERS' Fiduciary Duties to Plaintiffs

286. CalPERS, its Board, and employees (collectively CalPERS) have mandatory fiduciary duties, including to place its Members' interest before any other duty. (*Cal. Const.*, art XVI, §17; *O'Neal*, supra, *Hittle*, supra, *Probate Code*, *Gov't Code*, §20151.) Mandatory fiduciary duties include duties of loyalty, of good faith and fair dealing, to account, to inform, to not take advantage, and other duties. Id.

287. The fiduciary duties apply to the context of health benefits. *Government Code*, §

22792.

288. CalPERS also owes Plaintiffs mandatory duties to adequately and fully inform, especially about elections to benefits and contracts. (*Hittle v. Santa Barbara Cnty. Employees Ret. Assn.* (1985) 39 Cal.3d 374, 389-90.) CalPERS owes Plaintiffs a mandatory duty to provide timely and *accurate* information to its Members (*In re Application of Smith*, CalPERS' Precedential Decision No. 99-01 (March 31, 1999) ["The duty to inform and deal fairly with members also requires that the information conveyed be complete and unambiguous"].)

289. CalPERS' mandatory fiduciary and other duties include (i) the mandatory duty of loyalty of CalPERS' board, officers and employees to discharge their duties solely in the interest of Members and beneficiaries, which requires a higher duty than the "prudent person" standard (*Government Code,* §20151); (ii) the mandate that CalPERS and its Board are a trust that must be administered solely for the benefit of members (California *Constitution, O'Neal, supra, Hittle, supra, Probate Code, Government Code,* §20170); (iii) mandatory duties to account (*Government Code*, §§20178, 20225); (iv) mandatory duties to correct (*Government Code*, §§20160, 20164)., and (v) fiduciary and other mandatory duties in the *Probate Code* and other enactments.

290. CalPERS breaches its fiduciary duties as described herein, in ways that directly and proximately harm Heinz and the class, who suffer damages as a result.

II. Specific Fiduciary Duties and Breaches Thereof

291. **Duty to Deal Fairly and Act in Utmost Good Faith.** Where a fiduciary relationship exists, the fiduciary must act with the utmost good faith for the benefit of the other party. (*Persson v. Smart Inventions, Inc.* (2005) 125 Cal.App.4th 1141, 1160.)

292. CalPERS, however, has breached this duty by failing to act with the utmost good faith in the best interests of Plaintiffs, including as described throughout this Complaint.

293. CalPERS, however, has breached this duty by failing to act in the best interests of Plaintiffs

294. **Duty of Loyalty.** A fiduciary owes a duty of "undivided loyalty" to its beneficiary in all matters connected with the fiduciary relationship. (*Gilman v. Dalby* (2009) 176 Cal.App.4th

606, 614; *White Mountains Reins. Co. of America v. Borton Petrini, LLP* (2013) 221 Cal.App.4th 890, 902; see also Rest.3d, *Agency*, §§8.01-8.06.)

295. CalPERS' reduced "Allowable Amount," unreasonably low reimbursement, inadequate disclosure, and other acts or omissions, violates CalPERS' fiduciary duties of loyalty and to act in the best interests of the member.

296. CalPERS owes Plaintiffs the mandatory duty of loyalty of CalPERS' board, officers and employees to discharge their duties solely in the interest of Members and beneficiaries, which requires a higher duty than the "prudent person" standard (*Gov't Code*, §20151); and the mandate that CalPERS and its Board are a trust that must be administered solely for the benefit of members (*Gov't Code*, §20170). Under the California Constitution, as discussed *supra*, CalPERS, it's Board, and its employees must place the interest of the Members first. (*Cal. Const.*, art XVI, §17; *O'Neal*, supra, *Hittle*, supra, Probate Code, et al)

297. CalPERS (the agency, the Board, each Board member, and its employees and agents, et al), however, breaches this duty by dividing its loyalty between Plaintiffs and its contracted service providers (i.e. Anthem), including by placing the interest of the Anthem, and the pension system, before or greater than the interest of the Plaintiffs, including as described throughout this Complaint.

298. For example, although CalPERS could provide Anthem additional "compensation based on carrier performance" under *Government Code* Section 22864(b)(1), any "performance" based compensation paid to Anthem breach CalPERS duty of loyalty by compensating Anthem for reducing the reimbursement to class members.

299. For example, CalPERS' offering or providing compensation to Anthem for any efforts or results that reduce the reimbursement to members for out-of-network medical services below the reasonable rates is a breach of CalPERS duty of loyalty to members.

300. For example, CalPERS' establishing, administering, contracting, overseeing, or offering Anthem to administer a plan that provide Allowable Amounts and reimbursement at a rate substantially below the majority share of the UCR rates is a breach of the duty of loyalty.

301. **Duty to Account.** CalPERS is required to manage the subject matter of the

relationship with due care, must account to the beneficiary, and must keep the beneficiary fully informed as to all matters pertinent to the beneficiary's interest in the relationship. (*Oakland Raiders v. National Football League* (2005) 131 Cal.App.4th 621, 631.)

302. For the benefit of Members, *Government Code* sections impose on CalPERS mandatory duties to account (*Gov't Code*, §§20178, 20225); and mandatory duties to correct (*Gov't Code*, §§20160, 20164).

303. **Duty to Disclose All Material Facts and Share All Material Information.** CalPERS has a fiduciary duty to disclose fully all material facts concerning the transaction that might affect the principal's decision. (*Warren v. Merrill* (2006) 143 Cal.App.4th 96, 109; see also Witkin, Summary of California Law, *Agency and Employment*, §63.) CalPERS breaches its fiduciary duty to disclose all material facts as described throughout this *Complaint*. (*Cal. Const.*, art XVI, §17; *O'Neal, supra, Hittle, supra, Probate Code, et al.*)

304. A fiduciary's failure to share all information that is material to the principal's interests constitutes "constructive fraud," and eliminates the need to prove actual fraudulent intent. (*Michel v. Palos Verdes Network Group, Inc.* (2007) 156 Cal.App.4th 756, 762.)

305. CalPERS breached this duty by failing to disclose material facts, including failing to disclose facts that indicate that the third subpart indicating an "appropriate" standard is fundamentally different from the other subparts (and overrides the examples) or otherwise provide notice that Anthem or CalPERS can greatly reduce the "Allowable Amount".

306. **Fiduciary Duty to Inform.** CalPERS assumes the responsibility for correctly, accurately, timely, and adequately informing Plaintiffs of their rights and obligations.

307. CalPERS acknowledges, accepts , and has publicly taken on higher fiduciary standards around providing information, including a mandatory fiduciary duty to provide timely and *accurate* information to its members. (See *In re Application of Smith* (March 31, 1999) PERS Prec. Dec. No. 99-01 ["The duty to inform and deal fairly with members also requires that the information conveyed be complete and unambiguous"].)

308. The unreasonable process of setting, CalPERS' delegation to Anthem, Anthem's complete discretion, and lack of standards for the "Allowable Amount" rate were a material term

that CalPERS failed to inform Plaintiffs of.

309. CalPERS' publications, communications, and contracts failed to provide clear, conspicuous, and plain notice of the limitations, exclusions, coordination, offset, or the risk of loss. (*Russell v. Bankers Life Co.* (1975) 46 Cal.App.3d 405.)

310. The standardized forms and publications by which CalPERS sought to inform Plaintiffs about PPO insurance were inadequate, incomplete, and misleading and tantamount to the misrepresentation and concealment that are determined to be a wrongful breach of fiduciary duty in *Hittle, supra*, at 393-94.

311. **Duty to Disclose Information That Was More Easily Available to CalPERS through Its Special Position, Special Knowledge, and Expertise.** The low calculation of the "Allowable Amount" and reduced reimbursement was not patent or clear. The risk of a reduced reimbursement was not patent and not clear.

312. Through its special position as fiduciary, trustee, and sole provider of PPO health insurance, as well as its special expertise and knowledge, CalPERS was aware of the reduced reimbursement, and in far better position to explain and to disclose.

313. As the sole official information source about these benefits, CalPERS was in a far superior position to know, quantify, describe, disclose, understand, and explain the risks.

314. **Duty to Correct.** For the benefit of Members and their beneficiaries, *Government Code* sections 20160-20164 impose on CalPERS substantive mandatory duties to correct its errors or omissions throughout the lifetimes of CalPERS' Members and their beneficiaries, including in this action (and not limited to the administrative process).

315. Further, as CalPERS' and the OAH's administrative process does not allow for class-wide relief (*Rose v. City of Hayward, supra*), CalPERS is under the mandatory duty to make such corrections in the context of this case, i.e., outside the administrative process.

316. **Duty to Not Delegate Unreasonably.** CalPERS breached its fiduciary duties, including when CalPERS calculated or allowed Anthem to calculate the "Allowable Amounts" for Non-PPO medical expenses at a different and lower amount often much less than, including at a fraction of, the "Allowable Amount" that Anthem calculated or provided for PPO providers.

317. CalPERS wrongly delegated power and discretion to Anthem to determine an "Allowable Amount" that is inconsistent with the terms, representations, reasonable understanding, and goals of providing PPO coverage. CalPERS delegated the final say to Anthem over the Allowable Amounts, which in these matters is analogous to a regulation, as Anthem determines the uniform and final reimbursement rates (which CalPERS fails to change or oversee).

318. CalPERS failed to establish suitable safeguards, oversight, and administration of the claims process. CalPERS failed to delegate appropriately or otherwise failed to guide the power's use. CalPERS failed to protect against Anthem's misuse of the claims process, misuse of the delegated power to calculate the "Allowable Amount," or misuse of the delegated power to calculate the reimbursement. CalPERS may not delegate to Anthem the setting of the "Allowable Amount," without standards, especially when the "Allowable Amount" is secretly reduced, and especially where CalPERS is likely the entity that is paying the claims. This is especially true if Anthem has the potential of receiving compensation from CalPERS for Anthem's performance of the claims process, if the performance is related to Anthem's reducing the payment of claims that are otherwise legally required, reasonable in amount, and/or justified, including under the EOC. The doctrine of unlawful delegation requires the Legislature or a regulatory agency to exercise the final say over whether any particular regulation becomes law. (*Light v. State Water Resources Control Board* (2014) 226 Cal. App. 4th 1463

319. **Duty to Oversee Anthem and to Administer Correctly**. CalPERS failed to evaluate and independently verify that Anthem has calculated the "Allowable Amount" consistently, appropriately, and correctly with the law, and the definition or at adequate UCR amounts.

320. Instead, In this case, CalPERS failed to investigate Anthem and determine whether the "Allowable Amount" was calculated properly.

III. CalPERS' Breach of Its Fiduciary Duties

321. CalPERS breaches a range of fiduciary duties including, *inter alia*, (i) transferring risk and costs onto Plaintiff, including costs that should be reimbursed appropriately as

determined under a correct calculation of the Allowable Amount; (ii) failing to disclose that it will pay lower reimbursements and reduced the "Allowable Amount" for out-of-network services; (iii) dividing its loyalty such that it benefited itself or Anthem or the employers at the expense of members and enrollees, including if CalPERS paid compensation to Anthem for reducing reimbursements; (iv) failing to calculate the "Allowable Amount" correctly; (v) failing to structure, administer, oversee, calculate, and provide a reasonable or appropriate "Allowable Amount" so that it is in members best interest; (vi) failing to provide commensurate reimbursements for in network and out-of-network medical services; (vii) failing to provide "specific notice" of any reduced reimbursement or reduced "Allowable Amount" for out-of-network services; (viii) entering into standardized transactions on non-negotiable form contracts by which CalPERS, the Board, or the Anthem obtains an advantage, including by insufficient consideration or undue influence; including by reducing its burden to reimburse for nonemergency out-of-network medical expenses; (ix) not providing due process or notice; (x) failing to act in good faith and deal fairly, including as CalPERS sold secretly less valuable PPO insurance to Plaintiffs who sought "out-of-network" coverage; and (xi) in other ways described in this *Complaint*.

A. <u>CalPERS' Breach Of Its Fiduciary Duties Caused Harm to Plaintiffs</u>

322. Plaintiffs specifically suffer damages directly and proximately caused by CalPERS' breaches of its fiduciary duties, including by CalPERS and/or Anthem (i) transferring medical expenses onto Plaintiffs; (ii) transferring costs onto Plaintiffs associated with "out-of-network" medical costs that it purported to cover; (iii) failing to disclose that it will pay reduced and arbitrarily calculated reimbursements; (iv) failing to disclose that the most significant cost of "out-of-network" medical expenses is the greatly reduced "Allowable Amount" (not the percentage increases in co-pay); (v) failing to adequately inform Members about the material terms of the PPO insurance; (vi) dividing its loyalty such that some of the Plaintiffs' insurance premiums benefit Anthem; (vii) failing to disclose a change in the "Allowable Amount" under the third subpart; (viii) failing to calculate the reimbursement at the appropriate level or higher; (x) failing to calculate the term "Allowable Amount" consistent with the first two subparts; (xi)

failing to disclose that the PPO arrangement is not a standard PPO coverage; (xii) failing to calculate the PPO premium such that the reduced reimbursement is apparent; (xiii) failing to disclose the reduced reimbursement and reduced "Allowable Amount" for "out-of-network" medical services; (xiv) failing to account; (xv) failing to account for the premiums that do not provide a standard PPO coverage; (xvi) failing to require Anthem to use usual, customary and reasonable (UCR) reimbursement rates and Allowable Amounts; (xvii) failing to oversee that Anthem acts on CalPERS' behalf in the best interest of the member; (xviii) failing to act in good faith; (xix) failing to exercise appropriate care; (xx) failing to act to the fiduciary standard required; (xxi) failing to deal fairly; (xxi) taking an advantage for itself or Anthem or others; (xxii) allowing Anthem to determine the "Allowable Amount" without standards or guidelines; (xxiii) failing to investigate the basis for the allowable amounts provided under the PPO coverage; (xxiv) failing to return the premiums that are not associated with standard PPO Coverage; (xxv) filing to provide "specific notice" to those seeking "out-of-network" services that the PPO plan is very different and does not use usual, customary or reasonable reimbursement rates; (xxvi) failing to take into consideration Plaintiffs' intent to seek appropriate standard reimbursement for "out-of-network" medical services; (xxv) failing to inform in a manner that is not inherently ambiguous or uninformative; (xxvi) breaching its duty of good faith and fair dealing when it acts with even the slightest misrepresentation, concealment, threat, or adverse pressure of any kind; (xxvii) breaching its duty of good faith and fair dealing when it seeks PPO coverage under a standardized form agreement that contains a three part "Allowable Amount" definition, where one subpart is dramatically different than the other subparts; (xxviii) misleading policyholders by failing to use real world or accurate examples that show that the "Allowable Amount" for in network and "out-of-network" medical care is significantly different; (xxix) breaching its duty of loyalty and requirement to contract with Anthem for industry standard reimbursements; (xxx) entering into standardized transactions on nonnegotiable form contracts by which CalPERS, the Board, or Anthem obtains an advantage from the class members; (xxxi) obtaining an advantage without sufficient consideration; (xxxii) retaining an advantage received by insufficient reimbursement, excess policy premiums, lack of consideration

or undue influence; (xxxiii) adding adverse material terms to a voluntary contract after the fact; (xxiii) seeking to enforce a waiver; (xxxiv) not providing due process or notice; (xxxv) failing to take adequate precautions to protect Plaintiffs from Anthem's secret under reimbursement practices or policies; (xxxvi) breaching its duty of good faith and fair dealing when it used the term "PPO" and represented and transacted purported PPO insurance on the same standardized forms that compared it to standard PPO insurance or HMO coverage; (xxxvii) breaching its duty of good faith and fair dealing when it sold nonstandard PPO insurance coverage specifically to those that it knew sought "out-of-network" coverage; (xxxix) breaching its duty of good faith and fair dealing when it sold PPO coverage that was not suitable to people seeking "out-of-network" coverage; and (xxxx) in other ways described in this *Complaint*.

B. Breach Proximately Caused Damage

323. CalPERS' breach of fiduciary duty directly and proximately caused damage to class members, including when Plaintiffs are forced to accept reduced reimbursements and pay higher medical costs.

IV. Plaintiffs' Damages

324. Each Plaintiff suffered damage at the time they signed CalPERS' form contracts and then suffered increased reimbursement rates.

325. Each Plaintiff suffered reduced reimbursement and higher medical costs.

326. **Amount of Damages.** The beneficiary is entitled to recover in tort for all harm caused by the breach of duty arising from the fiduciary relationship. (See *Fair v. Bakhtiari, supra, at* 1153; *Rest. 2d Torts*, §874, comm. B.) Each Plaintiff is entitled to damages for all harm proximately caused by defendant's breach of fiduciary duty. (*Michelson v. Hamada* (1994) 29 Cal.App.4th 1566, 1582; see also *Civil Code*, §3333.)

327. The amount of damages is the amount of the under-reimbursement with interest charged from the date of payment of the underpaid claim to the time when the claims is correctly paid, plus attorney fees and other costs.

A. Mandatory Fiduciary Duties Intended to Protect Against the Type of Injuries That Plaintiffs Suffered

328. The constitutional, statutory, and adopted fiduciary duties imposed upon CalPERS, its Board, and the CalPERS employees were intended to protect against the type of harm that Plaintiffs' suffered.

B. Presumption of Reliance

329. Plaintiffs are presumed to rely on the representations in the standardized form contracts, and other writings.

330. Plaintiffs are presumed to rely on CalPERS, including on CalPERS acting in their best interests, on CalPERS putting the interest of the Members first, on CalPERS as trustee not taking an advantage, on CalPERS not being secretly adverse to them, on CalPERS disclosing all material terms in a clear manner, on CalPERS acting fairly and in good faith, on CalPERS not dividing its loyalties, on CalPERS accounting for all of Plaintiffs' money, on CalPERS reimbursing out-of-network medical services at a reasonable rate, on CalPERS interpreting and calculating the "Allowable Amount" in a reasonable and correct manner, on CalPERS not asserting a statute of limitations on corrections, on CalPERS not retaining monies that should be properly paid to Plaintiffs as reimbursements, and in other ways addressed in this *Complaint.*

331. **Presumption of Reliance, No Known Adversity.** There is no such evidence that Members thought or knew trustee turned adverse against them." (*Toedter v. Bradshaw, supra*, at 208; see also *Estate of Gump* at fn. 22.)

332. **Presumption of Reliance Shifts Burden onto CalPERS.** The effect of the presumption of reliance shifts the burden of proof and imposes upon CalPERS the burden of proof as to the nonexistence of the presumed fact across the class. (*Evid. Code*, §606; see *People v. Dubon* (2001) 90 Cal.App.4th 944; *Estate of Gelonese* (1974) 36 Cal.App.3d 854, 862-863.) *Church of the Merciful Savior v. Volunteers of America* (1960) 184 Cal.App.2d 851, (*Sheehan v. Sullivan* (1899) 126 Cal. 189, 193;

V. CalPERS' Mandatory Fiduciary Duties Trump Any Governmental Immunity

333. CalPERS is a trust and its Board members and employees are trustees that owe higher specific duties to Plaintiffs as beneficiaries. The constitutional duties are supreme over statutes and any conflicting legislation:

334. The California *Constitution* establishes CalPERS as a trust and the Board of Administration as trustee with fiduciary duties to Members, including to place the interest of Members first. Throughout this *Complaint*, Plaintiff has referred to the agency, the Board of Administration, and its employees collectively as "CalPERS" as they all owe mandatory fiduciary duties and/or are liable for breach of mandatory fiduciary duties under law. The CalPERS Board's mandatory fiduciary duties of loyalty to the Members takes precedence over any other duties (*Cal. Const.*, art XVI, §17). The PEMCHA statutes require mandatory duties.

335. The *Probate Code* duties and other fiduciary duties are mandatory duties. See *Hittle, O'Neal, Marzec, supra. Government Code* section 815.6 and other law provides that when a public entity is under a mandatory duty imposed by an enactment that is designed to protect against the risk of a particular kind of injury, the public entity is liable for an injury of that kind proximately caused by its failure to discharge the duty unless the public entity establishes that it exercised reasonable diligence to discharge that duty.

336. CalPERS' mandatory fiduciary and statutory duties are designed and intended to protect against the particular type of injury that Plaintiffs suffered. (*Gov't Code*, §815.6.) Plaintiffs' injuries arise as consequences that the enacting body sought to prevent through imposing the alleged mandatory duty. The legislative *purpose* of imposing the duties on CalPERS and its Board is to require CalPERS to put the interest of the Members first, to take no advantage, to act with loyalty in the interests of the members, to deal fairly and in good faith, to disclose information about plans to allow members to make reasonable choices, to provide UCR reimbursements, to account for their funds, to provide PPO insurance at reasonable reimbursement rates, and to otherwise perform the fiduciary duties to a high standard described in order to prevent the injuries that Plaintiffs suffered.

337. CalPERS has not exercised reasonable diligence.

338. After CalPERS owed fiduciary duties to Plaintiffs, CalPERS reached out by standardized publications and form contracts to provide health insurance under the guise of providing reasonable reimbursement for out-of-network charges. CalPERS' liabilities and damages arising from breach of its duties, including in the context of the presumption of

reliance, are not immunized.

339. **No Waiver of Rights.** Class members never waived any rights.

UNJUST ENRICHMENT

340. Plaintiffs assert an unjust enrichment cause of action against CalPERS and Anthem as they received and retained a benefit and then unjustly retained the benefit (under reimbursement) at the expense of Plaintiffs. *Peterson v. Cellco Partnership* (2008) 164 Cal. App. 4th 1583.

341. CalPERS and Anthem received the benefit of Heinz and the proposed class members' premiums for PPO insurance and retained the reimbursement monies that should have been paid to Plaintiffs, however, CalPERS and Anthem failed to pay the correct reimbursement and retained the moneys that they would have reimbursed to Heinz and the class members. Since CalPERS and Anthem were unjustly enriched at the expense of Heinz and the class, CalPERS and/or Anthem are required to make restitution to Heinz and the class." (Rest., Restitution § 1; see 66 Am.Jur.2d (2001 ed.).

MISREPRESENTATION

342. Plaintiffs assert a cause of action for misrepresentation against CalPERS and Anthem. Heinz and class suffer damage from Anthem's fraud by negligent misrepresentation as follows:

343. Anthem and/or CalPERS as defendants made representations as to a past or existing material fact.

344. The representations, including that the "Allowable Amount" would be appropriate, identical to in network service, the "Allowable Amount" would be adequate, the reimbursement at 60% of the consistent "Allowable Amount," and other representations, were material and untrue.

345. Regardless of CalPERS' and/or Anthem's actual belief, CalPERS and/or Anthem made the representations without any reasonable ground for believing them to be true.

346. The representations were made with the intent to induce Heinz and the class to rely upon them.

347. Heinz and the class were unaware of the falsity of the representations or must have acted in reliance upon the truth of the representations and were justified in relying upon the representation.

348. As a result of the reliance upon the truth of the representations, Heinz and the class sustained damage.[32]

349. In addition, the duty to inform is not equivalent to misrepresentation and instead is a constitutional fiduciary duty that is not immunized by mere statutes.[33] See *supra*.

BREACH OF IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

350. Heinz and class assert claims for breach of the implied covenant of good faith and fair dealing against CalPERS and Anthem. Heinz and the class suffer damage from CalPERS' and Anthem's breach of contract and breach of the implied promise of good faith and fair dealing. CalPERS and Anthems have unfairly interfered with the right of Plaintiffs to receive the reasonable reimbursement benefits of the PPO contract. Heinz and the proposed class claims that CalPERS and/or Anthem violated the duty to act fairly and in good faith. To establish this claim, Heinz and the proposed class will prove all of the following:

a) That Heinz and the proposed class and CalPERS and/or Anthem entered into a contract;

b) That Heinz and the proposed class did all, or substantially all of the significant things that the contract required Heinz and the proposed class to do [or that Heinz and the proposed class were excused from having to do those things];

c) That all conditions required for CalPERS and/or Anthem 's performance had occurred;

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[32] BAJI, No. 12.45; see *Byrum v. Brand* (1990) 219 C.A.3d 926, 940, 268 C.R. 609 [approving giving of instruction]; *Shamsian v. Atlantic Richfield Co.* (2003) 107 C.A.4th 967, 132 C.R.2d 635 [negligent misrepresentation requires false statement of past or existing material fact]; BAJI, No. 16.50.3 [form of special verdict—negligent misrepresentation]; CACI, No. 1903 [negligent misrepresentation], CACI, No. VF-1903 [form of special verdict—negligent misrepresentation.

[33] While CalPERS as a public entity may be immunized from liability for an injury caused by misrepresentation by an employee of the public entity whether or not such misrepresentation is negligent or intentional, Anthem is responsible for misrepresentation.

d) That CalPERS and/or Anthem unfairly interfered with Heinz and the proposed class 's right to receive the benefits of the PPO contract; and

e) That Heinz and the proposed class were harmed by CalPERS' and/or Anthem's conduct.

UNFAIR BUSINESS PRACTICES

351. Heinz and the proposed class assert claims under the UCL which permits a cause of action to be brought if CalPERS and/or Anthem's practice violates some other law. In effect, the CalPERS and/or Anthem's "unlawful" activity also makes them liable under § 17200 for a violation of the underlying law. [*Kasky v. Nike, Inc.* (2002) 27 C4th 939, 950, 119 CR2d 296, 304; *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 C4th 163, 180, 83 CR2d 548, 561; *Farmers Ins. Exch. v. Sup.Ct.* (1992) 2 C4th 377, 383, 6 CR2d 487, 491.

352. **CalPERS and Anthem violate the insurance code and insert terms into the contract that do not exist.** CalPERS and/or Anthem violate PEMCHA, the Knox Keene Act, the Constitution, fiduciary duties, the Probate Code, insurance standards, and contractual terms that make them liable under UCL. *See Smith v. State Farm Mutual Automobile Ins. Co.* (2001) 93 CA4th 700, 717,—Ins.C. § 11580.2; *AICCO, Inc. v. Insurance Co. of North America* (2001) 90 CA4th 579, 589,—insurer's transfer of "asbestos and environmental" coverages to another company without obtaining policyholders' consent in violation of CC § 1457; *Community Assisting Recovery, Inc. v. Aegis Ins. Co.* (2001) 92 CA4th 886,—alleged violations of Ins.C. §§ 2070, 2071; *Farmers Ins. Exch. v. Sup.Ct.* (1992) 2 C4th 377,—violation of Ins.C. §§ 1861.02 and 1861.05; *Walker v. Allstate Indemnity Co.* (2000) 77 CA4th 750,—violation of Ins.C. § 1861.05; see also *Chabner v. United of Omaha Life Ins. Co.* (9th Cir. 2000) 225 F3d 1042, 1050—Ins.C. § 10144.

353. CalPERS and/or Anthem assert a contract right to establish a reduced "Allowable Amount" for out-of-network services under the PPO coverage even though there is no right to that in contract. It is a violation of the UCL's proscription against "unlawful" practices to assert a

contractual right[34] that is not conferred in the contract or to include an unlawful provision in a *contract even if one never intends to enforce that provision.* [*People v. McKale* (1975) 25 C3d 626, 635; *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 CA4th 1284,; *People v. Custom Craft Carpets, Inc.* (1984) 159 CA3d 676, 683-684,; but cf. *Olsen v. Breeze, Inc.* (1996) 48 CA4th 608, 622-623.

354. CalPERS and/or Anthem acts violate the Unfair Business Practices Act that defines "unfair competition" as any "unlawful, unfair or fraudulent business practice and unfair, deceptive, untrue or misleading advertising ..." (§17200.)

355. CalPERS' and/or Anthem's acts that place unlawful or unenforceable terms in form contracts are violations of §17200. (*People v. McKale* (1979) 25 C3d 626, 634-635, [asserting a contractual right that one does not have]; *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 CA4th 1284; *People v. Custom Craft Carpets, Inc.* (1984) 159 CA3d 676, 683-684.) Systematically breaching a form contract affecting many consumers is a violation of §17200 (*Orkin Exterminating Co., Inc. v. FTC* (11th Cir. 1988) 849 F2d 1354, 1367-1368), or many producers (*Allied Grape Growers v. Bronco Wine Co.* (1988) 203 CA3d 432, 450-451). Taking advantage of a vulnerable group of consumers is a violation of § 17200. (See *FTC v. Keppel & Bros.* (1933) 291 US 304; *Committee on Children's Television, Inc. v. General Foods Corp.* (1983) 35 C3d 197.) Overreaching clauses in standard contracts is a violation of § 17200. (See *AMREP Corp.* (1983) 102 FTC 1362, aff'd (10th Cir. 1985) 768 F2d 1171 [forfeiture clauses in adhesion contracts].) Seller's systematic breach of a standard-form contract is a violation of § 17200. (See *Orkin Exterminating Co., Inc. v. FTC* (11th Cir. 1988) 849 F2d 1354.)

356. CalPERS' and/or Anthem's business practices are "fraudulent" within the meaning of §17200 as "members of the public are likely to be deceived." [*Committee on Children's*

[34] CalPERS and/or Anthem violate the disclosure and terms in the contract. Section 17200 claims may be brought to correct business practices that violate rules adopted by prior court decisions, even if the law at issue has never been codified. [*Bondanza v. Peninsula Hospital & Medical Center* (1979) 23 C3d 260, 266-268,—holding that the hospital's 33% surcharge on delinquent accounts was contractual penalty and thus "unlawful" under rule previously adopted in *Garrett v. Coast & Southern Fed. Sav. & Loan Ass'n* (1973) 9 C3d 731,; accord, *Community Assisting Recovery, Inc. v. Aegis Ins. Co.* (2001) 92 CA4th 886, 891,]

Television v. General Foods Corp. (1983) 35 C3d 197, 211; accord, *Kasky v. Nike, Inc.* (2002) 27 C4th 939; and *Prata v. Sup.Ct.* (2001) 91 CA4th 1128, 1144,] CalPERS and/or Anthem's advertisements of the PPO coverage potentially deceptive effect is measured by the audience to which it is addressed. Under the UCL and False Advertising statute, this will usually be the "reasonable person" standard. (*Committee on Children's Television*, supra, 35 C3d at 214.)

357. CalPERS' and/or Anthem's statements made in connection with the sale of goods or services constitutes "advertising." (*Chern v. Bank of America* (1976) 15 C3d 866, 875-876.) Advertising is "unfair, deceptive, untrue or misleading" if "members of the public are likely to be deceived." (*Committee on Children's Television, supr* 35 C3d 197, 211.)

358. **Consumers Legal Remedies Act.** CalPERS and/or Anthem violate a key provision of the Consumers Legal Remedies Act which prohibits "inserting an unconscionable provision in the contract." [*CC § 1770(s)]* Thus, a violation of § 1770(s) could constitute an "unlawful" or "unfair" business practice under § 17200.

EQUITABLE RELIEF

359. **Accounting.** Heinz and the class have demonstrated breaches of fiduciary duty, fraud, or that the accounts are complicated, and there is a dispute as to whether the money is owed. This requires an accounting. *Lester v. J.P. Morgan Chase Bank*, 926 F. Supp. 2d 1081 (N.D. Cal. 2013); *Teselle v. McLoughlin*, 173 Cal. App. 4th 156, (3d Dist. 2009).

360. **Petition for Writs, Stay.** In the alternative, Heinz asserts causes of action for Writ against CalPERS under *Code of Civil Procedure* §1094.5 and *Code of Civil Procedure* §1085. Heinz has received a final decision from CalPERS that is contrary to law, unsupported by the factual record, inconsistent with the weight of the evidence and that fails to address the class allegations. However, Heinz seeks to stay the writ causes of action until the other causes of action and proceedings have been adjudicated, including because CalPERS' administrative process cannot litigate class actions (*Rose v. City of Hayward*, supra.). CalPERS and Anthem required that Heinz as the class representative initially present his individual and class claims in the Anthem and CalPERS administrative processes, which he has timely and diligently completed. Heinz requests the writ should be stayed until the Court rules on the other causes of

action because the purposes of administrative presentation have been satisfied and the class claims must proceed.

PROCEDURAL ISSUES

I. Presentation of Claims in Administrative Process

361. Procedurally as required, Heinz filed a grievance in the Anthem administrative process. After presenting the claims and exhausting Anthem's administrative process, Heinz, both in an individual and in his representative capacity, then appealed, as required by the Plan and CalPERS, to CalPERS in CalPERS' capacity as administrator of the CalPERS Preferred Provider (PPO) plans ("Plans"). Heinz fully presented his individual and class claims in Anthem's and CalPERS administrative processes, generating a final decision. **Exhibit 1-2.** Heinz has presented the claims and exhausted the approximately seven-*year* long Anthem administrative process and the obligatory CalPERS administrative process for all claims from 2006 to December 2014.

362. Heinz submitted claims to Anthem for 2008 to the present. **Exhibit** 3-23, 27, 29-38, 54.

363. For example, Heinz submitted claims for 2008. **Exhibits 3-23, 27, 54.**

364. He then submitted additional claims for 2009. **Exhibit 3-23, 29, 54.**

365. Heinz timely filed a grievance in the Anthem process for all claims from 2008 to the present. **Exhibit 3-23, 27, 29-38, 54.**

366. Anthem reviewed the claims in the grievance process. **Exhibit 3-23, 27, 29-38, 54.**

367. Anthem accepted the exhaustion of the claims from 2008 to the present in the administrative process. **Exhibit 3-23, 27, 29-38, 54.**

368. Specifically, on November 2008, Anthem recognized that Heinz was submitting past claims and future claims on the same basis and that the claims would be ongoing into the future and represents all of the claims on the same subject matter when it wrote that the claims were from May 2, 2008 to the present. **Exhibit 15, 23, 54.** Anthem and CalPERS had duties to Heinz to notify him of reduced reimbursement, including as Heinz continued to see Dr. Walker

and submit ongoing claims for reimbursement, which Anthem and CalPERS accepted, and which were part of the administrative process. **Exhibits 3-23, 27, 29-38, 54.**

369. Heinz presented individual and class claims in the Anthem process including when he asserted that it misrepresents the terms of the health benefits plan, which would also affect all others similarly situated, including proposed class members. **Exhibit 16, 54.**

370. Anthem responded to Heinz's grievances and denied them. **Exhibits 3-23, 27, 29-38, 54.**

371. Anthem represented or implied that it reviewed other similarly situated doctors when Ed Haney of Anthem wrote, "this contract provides a very generous reimbursement rate when compared to the allowance in the region." **Page 2 of Exhibit 17.** There was no factual basis developed for Mr. Haney's representation or comparison.

372. On April 15, 2009, Anthem recognized that the appeal involved all past and future claims in the same generalized areas when it wrote that the appeal included claims to the present. **Page 2 of Exhibit 18.** There was no claim cut-off raised. **Exhibits 3-23, 27, 29-38, 54.**

373. Heinz continued to appeal timely on behalf of himself and others. **Exhibits 19, 20.**

374. As of March 17 2010, CalPERS and Anthem recognized that Heinz was maintaining his appeal. **Exhibits 21, 22.**

375. As of August 29, 2014, Anthem recognized that the appeal involved all claims up to August 29, 2014 when it indicated that the "Allowable Amount" from 2008 to 2010 was $113.31; the "Allowable Amount" from 2010 to 7/28/11 was $128.41; the "Allowable Amount" from 10/06/11 to 11/22/13 was $76.91, and the "Allowable Amount" from 05/03/13 to was 136.86. **Exhibits 14, 23, 54.**

376. Heinz exhausted the Anthem administrative process and properly began the required CalPERS administrative process. **Exhibit 3-23, 27, 29-38, 54.**

377. Heinz exhausted the CalPERS administrative process, requested reconsideration, and then received a final decision that occurred on May 17, 2017. **Exhibit 1, 2.** This Complaint timely followed.

378. A Petition for writ is not required to challenge CalPERS' final decision as these claims are recognized to be class claims that cannot be litigated in CalPERS administrative process. See *Rose v. City of Hayward, supra.* Any exhaustion of administrative process is excused, including because the CalPERS and OAH administrative process does not allow for class-wide relief. (*Rose v. City of Hayward, supra.*) CalPERS has waived any argument about presentation.

379. In any case, the time to challenge CalPERS final decision will be within 30 or 60 days of its final decision on May 17, with a final filing date before June 16.

380. **Heinz's Exhaustion of the Required Claims Process under 2 CCR § 599.518:** Heinz has presented the individual and class claims and exhausted CalPERS and Anthem's Appeal process under 2 CCR § 599.518. **Exhibits 1-23, 27, 29-38, 54.** Specifically, Heinz requested an administrative review and received a decision from the unit charged with the processing and oversight of health appeals. Heinz's request for an administrative hearing set forth the individual and class facts and law upon which the request was based. An administrative hearing was granted, and testimony and evidence was received. An administrative law judge issued a proposed decision and this decision was presented to the CalPERS board, finalized, and then reconsideration was not granted. The board finally adopted the proposed decision as its own decision at an open meeting on May 17, 2017. **Exhibit 1.**

381. Heinz was dissatisfied with the board's final decision and filed this Complaint which appealed the Board decisions and litigates in the Superior Court all of the claims listed herein, including the class claims for breach of fiduciary duty, breach of contract, breach of statutory violations et al that were presented in the administrative process but which were not ruled on because they are beyond the jurisdiction of CalPERS in the administrative process. Heinz has waited to pursue civil legal remedies until after exhausting administrative review and an administrative hearing. See 2 CCR § 599.518.

II. Presentation of the GCA claim

382. Heinz has filed a claim with the Office of Risk and Insurance Management, Government Operations Agency, Government Claims Program ("GCP") on April 21, 2017.

Heinz, on his own behalf and on behalf of all others similarly situated, (i) has satisfied the Government Claims Act ("GCA") claims presentation requirements under protest and/or (ii) is excused from compliance with the claim presentation requirement and/or (iii) is excused from claims presentation and exhaustion of an administrative process, including because Plaintiffs raise claims under the which CalPERS has no jurisdiction.

383. In May 2017, the GCP denied jurisdiction over the claim indicating that it was too late. Heinz subsequently remitted additional information about the tolling of the claims during the pendency of the administrative process. In June 2017, by form letter, VCA again denied the timeliness of the claim. However, it appears that the VCA will require Heinz to file a petition for late filing that Plaintiffs will make concurrently with the filing of this complaint.

384. The CGA claim will be deemed automatically denied on 45 days after April 21, 20176 which is June 5, 2017. The Complaint was timely filed thereafter. Heinz files his Complaint timely by June 17, 2017.

III. Anthem's and CalPERS' Waiver, Failure to Defend, and Failure to Exhaust

385. Heinz exhausted both the Anthem and CalPERS administrative processes, but Anthem and CalPERS failed to defend, waived their defenses, and failed to present their arguments in both processes. **Exhibits 1-61.**

386. Failure to assert the defense affirmatively in the answer will typically result in waiver of the defense. *James G. Freeman & Associates, Inc. v. Tanner*, 56 Cal.App.3d 1, 9, (1st Dist.1976); The defendant that fails to argue matters in the administrative process will be held to have waived the argument. *Major v. Western Home Ins. Co.*, 169 Cal.App.4th 1197, 1211, (4th Dist.2009).Heinz substantively exhausted the administrative remedy *Doyle v. City of Chino*, 117 Cal.App.3d 673, 681, (4th Dist.1981) .

IV. Heinz's Exhaustion is Sufficient on Behalf of Class

387. Heinz's presentation and exhaustion of all of the claims in the Anthem and CalPERS administrative processes is sufficient for all class members. The exhaustion requirement does not apply to all class members because Heinz exhausted the administrative remedies. *Rose v. City of Hayward*, supra; *Friends of Mammoth v. Board of Supervisors*, 8

Cal.3d 247, 267–68, (1972); *Tarkington v. California Unemployment Ins. Appeals Board*, 172 Cal.App.4th 1494, 1508-10, (2d Dist.2009); *Harrison v. Board of Supervisors*, 44 Cal.App.3d 852, 860–61, (1st Dist.1975); *Leff v. City of Monterey* Park, 218 Cal.App.3d 674, 681–82, (2d Dist.1990).

V. CalPERS and Anthem's Defective Administrative Processes

388. Both CalPERS' and Anthem's processes were defective. See **Exhibits 1-61.**

For example, the insurer is required *within 30 working days* to pay a covered health insurance claim or send written notice to the insured (and to the health care provider that provided the services at issue) that the claim is *contested or denied,* **stating the factual and/or legal basis for its action**. Interest accrues at the rate of 10% per annum on claims not paid or contested within the 30-working-day period. [See Ins.C. §§ 10123.13, 10123.147]

389. CalPERS and Anthem have never provided the factual or legal basis for the denials. They simply argued that their computer told them a different "Allowable Amount," which is not a sufficient factual or legal basis for denial.

390. Mistakes or delay by the third party administrator in carrying out such duties are imputed to the insurer, not the insured, thus protecting the group members' rights or claims. [*Elfstrom v. New York Life Ins. Co.*, supra, 67 C2d at 513-514,]

391. CalPERS and Anthem failed to supply sufficient information in the administrative process. "Reasonably relevant information" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements. Cal. Code Regs., tit. 28, § 1300.71 "Information necessary to determine payer liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the

plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements. Cal. Code Regs., tit. 28, § 1300.71

392. CalPERS and Anthem also failed to hold an administrative hearing in a reasonable time and failed to perform its duties in a reasonable manner as per these and similar regulations:

> (1) A plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider **shall provide an accurate and clear written explanation of the specific reasons for the action** taken within the timeframes specified in sections (g) and (h).
> *Cal. Code Regs., tit. 28, § 1300.71*

393. Including because of CalPERS' and Anthem's failures in the defective administrative process, Plaintiffs demand full discovery rights on all matters connected with the individual and class claims.

PLAINTIFFS' CLAIMS: DELAYED ACCRUAL

394. Heinz, on his own behalf and on behalf of all others similarly situated, is entitled to delayed accrual of the claims and cause of action under various grounds, including CalPERS' breach of fiduciary duties, impossibility of discovering the harm, tolling by CalPERS' and Anthem's administrative process, tolling because Heinz was required to wait to pursue civil legal remedies until after exhausting administrative review and an administrative hearing. See 2 CCR § 599.518, tolling because of health-related delays, lack of due process, lack of notice, and the other grounds identified herein. See including **Exhibits 1-61.**

395. Heinz, on his own behalf and on behalf of all others similarly situated, asserts delayed accrual and delayed discovery, including that the harm and cause of harm was not disclosed by CalPERS (and/or Anthem) or was concealed and was only recently discoverable by Plaintiff. Heinz asserts delayed accrual (and delayed discovery) as a beneficiary that was ignorant, without notice, and unaware of the nature of the harm until recently. See infra.

396. Delayed accrual (and delayed discovery) is particularly appropriate because

CalPERS is a fiduciary with enhanced duties to disclose[35] and to correct. (See *April Enterprises, Inc. v. KTTV* (1983) 147 Cal.App.3d 805, 827; *NBC Universal Media, LLC v. Superior Court* (2014) 225 Cal.App.4th 1222.) (*Moreno v. Sanchez* (2003) 106 Cal.App.4th1415, 1424 CalPERS has enhanced mandatory fiduciary duties, including pursuant to the California *Constitution,* common law, the *Probate Code, Civil Code, O'Neal, supra, Hittle, supra,* and *Government Code* sections, 20151, 20160 and 20164 are substantive duty that is not limited by any procedural statute of limitations or filing requirement. CalPERS' duty to correct is a substantive duty that is not bound by any procedural statute or jurisdictional limitations. (*City of Oakland v. Pub. Employees' Ret. Sys.* (2002) 95 Cal.App.4th 29, 45.)

397. Plaintiffs assert CalPERS' superior knowledge, superior bargaining position, its position as the sole provider of PPO insurance, also delays the accrual period.

I. Delayed Discovery

398. Heinz, on his own behalf and on behalf of all others similarly situated, asserts delayed discovery of Anthem's and/or CalPERS' policies, practices, calculation of the "Allowable Amount," under-reimbursement, rejection of payment of valid claims, nonpayment, breach of fiduciary duties, and the other matters raised herein. The discovery was delayed including because of CalPERS' and Anthem's hidden policies and practices, their opaque nondisclosure, the undisclosed practice of reducing the "Allowable Amount," constructive fraud, failure to account, breach of fiduciary and statutory duties, its requirement to exhaust two different administrative process that Heinz diligently proceeded through, CalPERS' withholding of accurate information, and other actions or omissions by CalPERS and/or Anthem.

399. Heinz, on his own behalf and on behalf of all others similarly situated, asserts discovery of the harm or cause of harm and any accrual of Plaintiffs' causes of action was delayed because of Plaintiffs' beneficiary status, lack of due process, lack of knowledge, ignorance of the harm or cause of the harm, inability to discover or decipher harm in the complexity, inability to discover the hidden terms, their reasonable reliance, their ignorance of

[35] No Duty of Inquiry. When the fiduciary is an express trustee, the beneficiary is not under a duty of inquiry. (*Di Grazia v. Anderlini* (1994) 22 Cal.App.4th 1337, 1345-346.)

the reduced "Allowable Amount" or other benefit, Anthem's and CalPERS' suppression of facts or law that would give notice, their request for rescission, or other action or status of Plaintiffs, including those caused or arising from Anthem and/or CalPERS' acts or omissions.

II. Delayed Accrual By Tolling In Administrative Process

400. Heinz, on his own behalf and on behalf of all others similarly situated, asserts delayed accrual is supported by the tolling of the period in the required administrative processes that Heinz diligently prosecuted. Heinz was required to wait to pursue civil legal remedies until after exhausting administrative review and an administrative hearing. See 2 CCR § 599.518. For a short time, Heinz's illness prevented him from immediately answering certain questions, but the illness is a valid excuse that was communicated to and accepted by CalPERS.

III. Facts About Accrual

401. Named Plaintiff Heinz and other members of the putative class were unaware of the cause, nature, extent, amount, or facts of their injury, harm, or loss. **Exhibits 1-61**.

402. Heinz, on his own behalf and on behalf of all others similarly situated, asserts CalPERS has still not disclosed sufficient law or facts to provide notice of its policies and practices that would put Plaintiffs on notice of the facts or the harm. CalPERS has still not disclosed the methodology for the calculation of the "Allowable Amount," the reason for the reduced reimbursement, risks, harms, and damages that would start the accrual of the causes of action.

403. Heinz, on his own behalf and on behalf of all others similarly situated, asserts as far as the date of the earliest accrual of the causes of action, that the earliest that anyone could have learned of CalPERS' improper policies and practices that have caused Plaintiffs harm arose during the administrative process and have been tolled by Heinz's diligent prosecution of the administrative process until now.

404. Heinz, on his own behalf and on behalf of all others similarly situated, asserts accrual of their causes of action and discovery of Anthem and CalPERS' policies, practices, and under reimbursement was delayed, including because of Anthem's practices and nondisclosure, its failure to give notice, its requirement to exhaust administrative processes, its withholding of

accurate information, and other actions or omissions by CalPERS and Anthem.

INTEREST

405. Plaintiffs seek interest, including the loss of use of their money or the interest that they could have earned if they had been properly reimbursed in a timely manner near the time that the claim was presented, pursuant to the California *Constitution*, art. 15, §1, and *Civil Code* sections 1955, 3281, 3287, 3288, and/or 3289. Interest accrues at the rate of 10% per annum on claims not paid or contested within the 30-working-day period. See Ins.C. §§ 10123.13.

406. Plaintiffs are entitled to interest from the date of that the proper reimbursement should have been paid.

ATTORNEY FEES

407. Plaintiffs seek attorneys' fees, including from CalPERS and/or Anthem, and/or pursuant to contract between named Plaintiffs and their counsel, under Code of Civil Procedure section 1021.5, the common fund theory, the substantial benefit equitable doctrine, and other relevant sections or doctrines.

408. Plaintiffs seek the Court to order CalPERS and/or Anthem to pay all of the attorney fees in the highest amount available to the attorneys under the various theories, statutes, or authorities set forth in this Complaint.

409. As there are multiple grounds for attorney fee awards, Plaintiffs seek the benefit of the highest applicable or cumulative award, including under one or more of (i) by contract with the named representative for the class and on the total value of the recovery for all class members; (ii) as a percentage of recovery of all the benefits or advantage conferred to or on all members of the class; (iii) under statutes; (iv) pursuant to the common fund doctrine; (v) pursuant to the substantial benefit doctrine; (vi) pursuant to the private attorney general doctrine; (vii) pursuant to the doctrine of equitable apportionment of attorney fees; (viii) as enforcement of an important right or statute; (ix) as affecting the public interest; (x) as an inherent cost of litigation; (xi) under the percentage method; (xii) as a benefit to the class of the action; (xiii) as a contract for service by the named class representatives with counsel for purposes of litigating this class action for the benefit of the class representative and other individuals in the proposed class;

and (viii) all other theories of recovery.

410. Plaintiff has signed a contract to pay attorney fees on behalf of the class in order to prosecute this action. Plaintiff as class representative has agreed to request the Court to grant the attorney fees under any and all theories of recovery. Plaintiff requests that the Court award attorney fees in the amount or pursuant to the terms of the contract between named Plaintiff Heinz and counsel, including as a percentage of the total recovery for all class members. Plaintiff seeks attorney fees under statute, including *Code of Civil Procedure* sections 1021 and 1021.5, et seq.

411. Under the common fund or equitable benefit doctrine, Plaintiffs seek recovery that will result in a common fund of traceable property from which attorney fees may be paid, where identifiable beneficiaries must pay fees in a quantifiable amount, including as percentages of the benefits arising from the litigation. If recovery is generated but an actual fund from which to pay fees has not been created, Plaintiffs seek an award of attorney fees from the recovery generated or other monies or advantage provided to each class member, including attorney fees as deducted prorated as a percentage from the recovery generated or payable to each participant.

412. Plaintiffs also seek attorney fees and costs under the substantial benefit doctrine. Litigation initiated by Plaintiffs provides substantial actual and concrete benefits to those who receive benefits, advantage, interest, or monies arising from the action, including non–pecuniary benefits that arise in an ascertainable class. Those who receive a benefit should bear the prorated costs of securing that benefit. Each class member shall bear a portion of the costs, including preventing unjust enrichment. (See *Mandel v. Hodges* (1976) 54 Cal.App.3d 596.)

FIRST CAUSE OF ACTION

(For Breach of Contract Against Anthem and/or CalPERS)

413. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

414. Plaintiffs entered into a written contract with CalPERS and/or Anthem, including which are attached as **Exhibits** 24-26, 28 -32, 34, 36, 38-55.

415. Plaintiffs entered into an implied contract with CalPERS and/or Anthem, based in

the terms that are attached in writing in **Exhibits** 24-26, 28 -32, 34, 36, 38-55.

416. CalPERS and/or Anthem breached the contracts, including by failing to pay reasonable reimbursements rates and provide reasonable Allowable Amounts.

417. CalPERS and/or Anthem breach of the contract terms directly caused Plaintiffs damages in increased payments for medical costs.

418. CalPERS and/or Anthem are responsible for those extra costs, plus interest, and attorney fees.

419. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

SECOND CAUSE OF ACTON

(For Breach of Fiduciary Duty Against CalPERS)

420. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

421. CalPERS owes fiduciary duties to Plaintiffs.

422. CalPERS breached its duties, including based on a presumption of reliance, that directly and proximately caused and in the future will cause Plaintiffs damage in an amount to be proven at trial.

423. Plaintiffs seek damages and recovery for breach of fiduciary duty, interest, attorney fees, and other recovery to place Plaintiffs back in the place that they would have been had CalPERS not breached its fiduciary duties to them, including with respect to the PPO contract.

424. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

THIRD CAUSE OF ACTON

(For Unjust Enrichment Against Anthem and CalPERS

425. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

426. CalPERS and Anthem retained benefits that are not properly theirs in the under-

reimbursement and those benefits should be paid and provided to Plaintiffs.

427. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

FOURTH CAUSE OF ACTION

(For Misrepresentation)

428. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

429. Anthem and CalPERS misrepresented the material terms of the PPO coverage

430. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

FIFTH CAUSE OF ACTION

(For Writs Against CalPERS)

431. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

432. In the alternative, Plaintiffs seeks a writ of mandate under CCP 1085 and a writ of administrative mandamus under CCP 1094.5 against CalPERS as its final decision in Exhibit 1 is contrary to law, unsupported by the facts in the record, the weight of the evidence does not support the findings, and the final decision is procedurally defective, including as CalPERS wrongly delegated authority to Anthem to determine the "Allowable Amount" without sufficient factual or legal support

433. Plaintiffs wish the cause of action for writ be stayed until the other issues are resolved

434. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

SIXTH CAUSE OF ACTION

(Unfair Business Practices Against Anthem)

435. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

436. CalPERS and Anthem engaged in unfair business practices that damages Plaintiffs.

437. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

SEVENTH CAUSE OF ACTION

Breach of Covenant of Good Faith and Fair Dealing

438. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

439. Plaintiffs entered into a written contract with CalPERS and Anthem

440. Plaintiffs entered into an implied contract with CalPERS and Anthem, base dint he terms that are attached in writing.

441. CalPERS and Anthem breached the contracts by failing to pay reasonable reimbursements rates and reasonable Allowable Amounts.

442. CalPERS and Anthem breach of the contract terms directly caused Plaintiffs damages in increased payments for medical costs.

443. CalPERS and Anthem breached the implied covenant of good faith and fair dealing.

444. CalPERS an Anthem are responsible for those extra costs, plus interest, and attorney fees.

445. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

EIGHTH CAUSE OF ACTION

(Violation of Statutory Duties)

446. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

447. CalPERS and/or Anthem violated mandatory statutory duties and rights owed to Heinz and the class, the breach of which caused damages to Heinz and the class.

448. CalPERS and/or Anthem violated provisions of PEMCHA;

449. CalPERS and/or Anthem violated provisions of the Knox Keene Act;

450. CalPERS and/or Anthem violated provisions of the Public Employees Retirement Law;

451. CalPERS violated provisions of the Constitution and the Probate Code involving fiduciary duties;

452. CalPERS and/or Anthem violation of the statutory provisions cause damages to Heinz and the class in an amount to be proven at trial; and

453. Plaintiffs seek all relief that the court may order, including as necessary to adjust the equities between the parties.

NINTH CAUSE OF ACTION

Other Relief, Including Equitable Relief, and Attorneys' Fees)

454. Plaintiffs hereby incorporate and restate all allegations set out above as though set forth in full herein.

455. CalPERS and/or Anthem have been unjustly enriched at Heinz and Plaintiffs' expense and Plaintiffs are entitled to CalPERS and/or Anthem disgorgement of monies and profits that they have retained in excess of their legal rights;

456. Plaintiffs are entitled to equitable relief, including an accounting, in order to place the class members back in the position that they should have been had CalPERS and/or Anthem properly performed their duties;

457. Plaintiffs are entitled to pre-judgment, post-judgment, and all other interest on all monies or investment of money transferred and continuing cumulatively until paid.

458. Plaintiffs request that the Court order an accounting.

459. Plaintiffs request that the Court order a constructive trust.

460. Plaintiffs request that the Court order the payment of attorneys' fees.

461. Plaintiffs request that the Court award attorneys' fees, costs, and other relief, including payable from CalPERS directly, in addition to any sums that CalPERS transfers as restitution, relief, or other recovery, pursuant to the contract terms;

462. Plaintiffs are entitled to fees, recovery, costs and such other relief as the Court

deems just and proper.

PRAYER FOR RELIEF

Wherefore, Plaintiffs pray for a judgment against Defendants, the California Public Employees' Retirement System, and the Board of Administration of the California Public Employees' Retirement System, and Anthem Blue Cross Life & Health Insurance Company as follows:

1. Award contract damages;

2. Award recovery of damages for breach of fiduciary duty in an amount to make each Plaintiff whole;

3. Alternatively, grant Plaintiffs reasonable reimbursement

4. Award consequential damages in Plaintiffs' favor, including expenses incurred;

5. Award interest as described above, in addition to any sums that CalPERS or Anthem transfers as restitution, relief, or other recovery;

6. Award any and all additional and further relief as is necessary to adjust the equities between CalPERS and/or Anthem and Plaintiffs and to restore the status quo. (*Civil Code*, §1692);

7. Order an accounting of all monies that Plaintiffs and class members have paid into or contributed to CalPERS or related funds (i) associated with reduced reimbursement rates associated with Plaintiffs' PPO insurance or (ii) associated with underpayments made pursuant to the PPO coverage ;

8. Award attorneys' fees, costs, and other relief, including payable from CalPERS and Anthem directly, in addition to any sums that CalPERS and/or Anthem transfers as restitution, relief, or other recovery, pursuant to the contract terms;

9. Alternatively, award attorneys' fees, including an award of costs and attorneys' fees to be made, including pursuant to contract terms;

10. Alternatively, award attorneys' fees, including an award of costs and attorneys' fees to be made, under *Code of Civil Procedure* section 1021.5, under the common fund theory

and/or under the substantial benefit theory, and other relevant sections, payable from the monies associated with damages or the monies restituted or the interest thereon; and

11. Award any and all additional and further relief as the Court may deem proper.

Dated: June 12, 2017

By: _____
John Michael Jensen, Esq. SBN 176813
Attorney for Plaintiffs

EXHIBITS LODGED CONCURRENTLY

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial.

Dated: June 12, 2017

By: _____
John Michael Jensen, Esq. SBN 176813
Attorney for Plaintiffs