IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

BECKY A. WEAVER, and
RODNEY WEAVER,
individually and on behalf of all others
similarly situated,

Plaintiffs,

vs.

Civil Action No. _____

AEGON USA, LLC, f/k/a AEGON USA INC.;
And TRANSAMERICA LIFE INSURANCE
COMPANY, f/k/a LIFE INVESTORS
INSURANCE COMPANY OF
AMERICA f/k/a EQUITY NATIONAL
LIFE INSURANCE COMPANY,

Defendants.

ORIGINAL CLASS ACTION COMPLAINT

(JURY TRIAL DEMANDED)

Plaintiffs Becky A. Weaver and Rodney Weaver (hereinafter "**Plaintiffs**"), complaining of the above-named Defendants, would respectfully show the Court as follows:

I.
PARTIES

1. Plaintiffs are citizens of South Carolina and residents of Timmonsville, South Carolina. At all times relevant hereto, Plaintiffs are (and were) owners of a supplemental cancer insurance policy issued by Equity National Life Insurance Company (hereinafter "**Equity National**"), the predecessor-in-interest of Life Investors Insurance Company of America (hereinafter "**Life Investors**"), the predecessor-in-interest of Transamerica Life Insurance Company (hereinafter "**Transamerica**") and administered by AEGON USA, LLC, formerly known as AEGON USA INC. (hereinafter "**AEGON USA**") through its various wholly owned

subsidiaries, including Defendant Transamerica. Plaintiffs purchased their supplemental cancer insurance policy in South Carolina.

2. Defendant AEGON USA is an Iowa corporation that provides insurance products and services to consumers in South Carolina and throughout the United States, through wholly owned subsidiaries and/or through itself. Defendant AEGON USA's principal place of business is, upon information and belief, in Cedar Rapids, Iowa.

3. Defendant AEGON USA is the parent company of several subsidiaries that provide services to Defendant Transamerica.

4. Defendant AEGON USA controls, through its various subsidiaries, marketing, selling, underwriting and related financial aspects of Defendant Transamerica's insurance policies.

5. Upon information and belief, Defendant AEGON USA is a wholly owned subsidiary of AEGON NV, a Dutch corporation.

6. Upon information and belief, Defendant AEGON USA provides its annual reporting through the annual reports of AEGON NV.

7. Upon information and belief, in those annual reports, Defendant AEGON USA reports the assets, liabilities and cash flow of Defendant Transamerica as assets, liabilities and cash flow of Defendant AEGON USA, and ultimately AEGON NV.

8. Upon information and belief, employees of Defendant AEGON USA or a subsidiary of Defendant AEGON USA determines Plaintiffs' entitlement to benefits under the insurance policy at issue.

9. Upon information and belief, Defendant Transamerica has a contract with Defendant AEGON USA or one of its subsidiaries to provide claims handling services and Defendant AEGON USA or one of its subsidiaries has assumed certain duties under the contract at issue.

10. Upon information and belief, in reports to the various state insurance commissioners and agencies, Defendant Transamerica uses the assets of (or loans from) its parent company Defendant AEGON USA to meet certain liquidity requirements.

11. Upon information and belief, the monthly premium paid by Plaintiffs and the members of the Proposed Class identified herein are (and were) ultimately paid to Defendant AEGON USA.

12. Defendant Transamerica is a foreign insurance company, organized under the laws of Iowa and authorized to transact business of insurance in South Carolina, who sells and administers, among other insurance products, supplemental cancer insurance policies in several states and territories of the United States, including South Carolina.

13. Upon information and belief, Defendant Transamerica has the following parent corporations: Transamerica International Holding, Inc. (direct parent); AEGON USA, LLC; AEGON U.S. Holding Corporation; Transamerica Corporation; The AEGON Trust; AEGON International B.V.; and AEGON, N.V.

14. On October 2, 2008, Defendant hereinafter merged with, became a part of and subsumed the interests of Life Investors which no longer exists.

15. On December 31, 2001, before its merger with Defendant Transamerica, Life Investors previously merged with, became a part of and subsumed the interests of Equity National, which no longer exists.

16. Defendant TRANSAMERICA is, therefore, the successor-in-interest of both Life Investors and Equity National causing a judgment against Life Investors or Equity National to be in every legal sense a judgment against Defendant TRANSAMERICA and/or vice versa.

17. Defendant's predecessor-in-interest, Equity National, issued and delivered to Plaintiffs the supplemental cancer insurance policy subject to this suit (hereafter, the "**Policy**") sometime during the late 1970s or early 1980s.

18. Plaintiffs bring this action pursuant to Fed. R. Civ. P. 23 on behalf of themselves and all persons throughout the United States, its Possession and Territories, or alternatively, just residents of South Carolina, who:

a. were not named Plaintiffs in the class action styled *Edison Runyan, et al. v. Transamerica Life Insurance Company, et al.*, No. CV-09-2066-3, formerly pending in the state circuit court of Pulaski County, Arkansas (hereafter, the "***Runyan* suit**");

b. are or were an insured, covered person or otherwise entitled to coverage under a supplemental cancer insurance policy (including any rider, endorsement, or policy amendment) that:

i. was issued, delivered or is presently administered by Defendants; and

ii. measures some policy benefits by the treating medical providers' "actual charges" or "charges" or other synonymous term for specified healthcare goods, services and/or treatments.

(hereafter, the "**Proposed Class**")

II.
JURISDICTION

19. This Court has diversity jurisdiction over this action pursuant to 28 U.S.C. § 1332 because it is a suit between citizens of different states over an amount in controversy that exceeds $75,000.00 and otherwise pursuant to the Class Action Fairness Act of 2005, 28 U.S.C.§§ 1332(d), 1453 and 1711-1715 ("**CAFA**").

20. Moreover, this Court also has federal question jurisdiction pursuant to 28 U.S.C. §§ 2201 and 1331 to decide and declare whether:

a. the term "actual charges" or other synonymous terms used within the supplemental insurance policies issued, delivered and/or administered by Defendants means the greater, "billed" or "pre-negotiated" charges or the reduced amount the provider agrees to accept from the patient's other, unrelated major medical insurance company in exchange for steerage (*i.e.*, "discounted" or "post-negotiated" charges);

b. Defendants are precluded from taking the position that the term "actual charges" within the supplemental cancer policies issued, delivered and/or administered by Defendants means the "discounted" or "post-negotiated" charges because three (3) federal courts have already entered separate judgments against Defendants on that precise issue after fully litigated proceedings in *Gooch v. Life Investors Ins. Co. of Am.*, 264 F.R.D. 340 (M.D. Tenn. 2009) (the "***Gooch* Judgment**"), *Lindley v. Life Investors Ins. Co. of Am.*, No. 08-CV-0379-CVE-PJC, 2009 WL 2163513, at *1 (N.D. Okla. July 17, 2009) (the "***Lindley* Judgment**"), and *Smith v. Life Investors Ins. Co. Of Am.*, No. 2:07-cv-681, 2009 WL 3756911, at *8 (W.D. Pa. Nov. 6, 2009) (the "***Smith* Judgment**");

c. Defendants are precluded from taking the position that the final judgment entered by the state court of Pulaski County, Arkansas in the matter styled *Edison Runyan, et al. v. Transamerica Life Insurance Company, et al.*, No. CV-09-2066-3 (the "***Runyan* Judgment**"), is binding upon Plaintiffs and the members of the Proposed Class given that a federal court in South

Carolina has already entered a decision against Defendants on that precise issue within the context of the fully litigated proceedings in *Hege v. Aegon USA, LLC, et. al*., No. 8:10-1578-GRA (D. S.C.) (hereinafter, the "***Hege* Judgment**"), a copy of which is attached hereto as **Exhibit 1**; and

d. the final judgment entered by the state court of Pulaski County, Arkansas in the matter styled *Edison Runyan, et al. v. Transamerica Life Insurance Company, et al.*, No. CV-09-2066-3 (the "***Runyan* Judgment**"), which ostensibly binds Plaintiffs and the members of the Proposed Class, is entitled to Full Faith & Credit, U.S. Const. Art. IV, § 1, or whether the *Runyan* Judgment was, instead, rendered in violation of either the Due Process Clause of the Fourteenth Amendment, U.S. Const. Amend. XIV, and/or the First Amendment, U.S. Const. Amend. I.

III.
VENUE

21. Venue is proper in this District pursuant to 28 U.S.C. § 1391(a) and is premised on the fact that Defendants do business in this District and various events, acts and omissions relating to the claim occurred in this District, including repetitive acts of selling or servicing insurance products in this District. Because of Defendants' contacts with the Proposed Class, including the collection of monthly premiums, directly or indirectly from the Proposed Class, as well as the sales and administration of policies and claims, Defendants are each subject to personal jurisdiction in this District.

IV.
CONDITIONS PRECEDENT

Plaintiffs incorporate all her prior allegations here by reference.

22. All conditions precedent to Plaintiffs instituting their action have occurred, been performed, were waived or have otherwise been satisfied.

23. Defendant presently maintains and administers Plaintiffs' Policy.

24. At all times since Plaintiffs purchased the Policy, Plaintiffs paid all policy premiums required to continue her Policy and keep its coverage in full force and effect.

25. Defendant has never cancelled or suspended Plaintiffs' Policy.

26. Defendant has never cancelled Plaintiffs' Policy in accordance with federal law, including regulations.

27. While the Policy was in full force and effect, Plaintiff Becky A. Weaver was positively diagnosed with and treated for cancer.

28. Plaintiff Becky A. Weaver has received cancer treatment from medical providers.

29. Plaintiff Becky A. Weaver has received medical bills, charges and has incurred expenses resulting from her positive diagnosis of cancer.

30. Plaintiff submitted the billed charges for the aforementioned cancer-related treatment to Defendants and requested Defendants pay them benefits pursuant to the terms and conditions of the Policy.

31. Defendants paid Plaintiff covered benefits based on the reduced "discounted" or "post-negotiated" charges rather than the greater, "billed" or "pre-negotiated" charges.

32. It is foreseeable that Plaintiff will receive future cancer treatment from medical providers and receive consequent charges and incur additional expenses as a result of her positive diagnosis of cancer which will further entitle her to receive the cash benefits payable under the terms of their Policy.

V.
FACTS GIVING RISE TO PLAINTIFFS' CAUSE OF ACTION

Plaintiffs incorporate all their prior allegations here by reference.

A. THE IMPORTANT DISTINCTIONS BETWEEN "SUPPLEMENTAL" AND "MAJOR-MEDICAL" INSURANCE COVERAGE RELEVANT TO THIS LAWSUIT

33. The supplemental cancer policies sold and/or administered by Defendants are considered "*supplemental*" insurance as opposed to comprehensive or "*major-medical*" health insurance coverage such as provided by Blue Cross/Blue Shield or Medicare.

34. Traditional "major-medical" insurance is designed to leverage the market power of large *groups* of insureds and to indemnify them of their medical debts.

35. Because "major-medical" policies are designed to indemnify policyholders for medical debt, such plans generally provide for an assignment of benefits to the medical provider who, upon rendering medical services, becomes a third-party beneficiary of the insurance contract.

36. There is, of course, *no* requirement that the "major-medical" insurer satisfy the providers' charges in "*cash*" alone. Rather, "major-medical" providers are only required to discharge the patient's medical debt through whatever legal means are available to them, including the use of *non*-cash forms of economic remuneration.

37. Conversely, Defendants' "supplemental" cancer insurance is generally sold on an *individual* basis and is only designed to put "*cash*" in the patient's pocket to help defray the consequential costs, burdens and other indirect expenses (travel, lodging, lost wages, home maintenance) associated with cancer that are *not* covered by "major-medical" insurance.

38. The policyholder may use these "supplemental" cash benefits for any reason they choose.

39. The supplemental cancer policies sold and/or administered by Defendants employ various indexes to measure the different types of cash benefits payable thereunder.

40. The cash benefit for several cancer treatments set forth in these policies are measured by a cancer treatment provider's "actual charges" or other, synonymous terms.

41. And, because the very nature of "supplemental" insurance is to cover the otherwise *uninsured* costs of cancer, Defendants necessarily pay its cash benefits directly to the insured "*without regard*" to any other insurance the insured may have.

42. The very different purposes behind "major-medical" and "supplemental" insurance coverage necessarily impose different contractual obligations upon each type of

insurer and, consequently, different options are available to each of them to discharge those obligations.

43. Whereas "major-medical" insurers may satisfy a provider's charges - and consequently, its obligation to the patient - by using both the cash and *non*-cash forms of economic value at their disposal, "supplemental" insurers can only pay *cash* directly to the insured to satisfy their separate contractual obligation.

B. UNLIKE THEIR "SUPPLEMENTAL" COUNTERPARTS, "MAJOR-MEDICAL" INSURERS ENJOY MARKET POWER WHICH THEY LEVERAGE TO SATISFY A SIGNIFICANT PORTION OF A PROVIDER'S CHARGES WITH *NON*-CASH, ECONOMIC *VALUE OF PATIENT "STEERAGE"*

44. *"**Steerage**" is a form of non-cash remuneration that re*presents a ***quantifiable, economic value***. Selected health plans, for example, often provide a medical provider with "steerage" by actively encouraging its insureds to seek out the services of certain "preferred-providers" by offering them financial incentives such as reduced co-payments and deductibles when the insured chooses to receive medical treatment from those providers.

45. "Steerage", therefore, represents quantifiable, economic value to medical providers.

46. In our free-market society, medical providers who desire to receive the economic value of "steerage" from "major-medical" providers obviously have to give these "major-medical" insurers something of value in exchange.

47. In return for patient "steerage," the providers discount their usual and customary fees for medical services. Providers are willing to provide a cash discount to these insurers because the lesser "cash-only" amount they accept is offset by the value of the increased volume of patients they will serve as a result of the insurance company's steering efforts.

48. Naturally, if steerage did not represent real, quantifiable economic value, then providers would have little or no reason to give that insurer a lower cash rate for rendering medical care. This is why, typically, only health insurers with substantial market strength representing a sizable book of business are able to induce providers to sign contracts containing steerage discount agreements.

49. So, in reality, a "preferred-provider" discount is not just a gratuitous "write-off" from a "fictitious" bill. Instead, these cash discounts constitute quantifiable units of economic value that the negotiating medical providers deem equivalent to the value of the patient steerage they bargained to receive.

50. Another economic reality is that the agreement from which cash-discounts for patient steerage are negotiated is between only the medical provider and the "major-medical" insurer, not "supplemental" insurers like Defendants. "Supplemental" insurers like Defendants, are complete stranger to these contracts.

51. "Supplemental" insurers like Defendants have no contractual relationship with the medical provider because its supplemented cash benefits are, by definition, paid directly to the patient, not to the medical provider.

52. Accordingly, as a "supplemental" insurer, Defendants have no patient "steerage" or any other economic value to offer treating providers that could induce them to accept less in cash then the full amount of their bill.

53. Putting the actual market realities of the medical-insurance industry in context, "supplemental" insurers like Defendant cannot, in good faith, take the position that they too are entitled to a benefit from a preferred-provider discount that a separate "major-medical" insurer gave significant consideration to receive for themselves.

C. WHEN DEFENDANT SOLD ITS "SUPPLEMENTAL" CANCER POLICIES TO PLAINTIFFS AND THE MEMBERS OF THE PROPOSED CLASS, DEFENDANT INTERPRETED "ACTUAL CHARGES" TO MEAN THE PROVIDER'S GREATER "BILLED" OR "PRE-NEGOTIATED" CHARGES AND EXPRESSLY DISAGREED THAT THE TERM WAS INTENDED TO MEAN A PROVIDER'S REDUCED, "DISCOUNTED" OR "POST-NEGOTIATED" CHARGES

54. Numerous health care dictionaries, industry journals and other medical insurance authorities define 'actual charge' as the "billed" or "pre-negotiated" charges, including for example, MOSBY'S MEDICAL, NURSING, AND ALLIED HEALTH DICTIONARY 26 (4th ed.1994) ("**actual charge**, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); and Lee Hyde, The McGraw-Hill Essential Dictionary of Health Care 133 (1988) ("**actual charge**. The amount a physician or other practitioner actually bills a patient or his insurance for a medical service or procedure.").

55. It is understood and accepted throughout the medical-insurance industry that "actual charges" means a provider's "billed" or "pre-negotiated" charges.

56. In fact, for over 30 years since the 1970s until May 2006, Defendants and their predecessors-in-interest, interpreted "actual charges" to mean a provider's "billed" or "pre-negotiated" charges.

57. Numerous times throughout this 30 year time-span, Defendant and its predecessors-in-interest explained to insurance regulators across the country that it understood and interpreted "actual charges" to mean a provider's "billed" or "pre-negotiated" charges and without regard to the lesser "cash-only" portion medical providers may accept from "major-medical" insurers in exchange for patient steerage.

58. In November 1997, Defendants expressly acknowledged that they, in fact, interpreted "actual charges" as a provider's "billed" or "pre-negotiated" charges and, consequently, they do not pursue information regarding provider discounts when determining cash benefits payable under its supplemental cancer policies.

59. The only time that Defendants ever included a definition of "actual charges" in one of its "supplemental" cancer policies, they defined the term to mean "the amount billed for the treatment ***before any insurance discounts***, other insurance payments, reductions or discounts of any kind".

60. Given that Defendants have, for decades, historically interpreted "actual charges" to mean the "billed" or "pre-negotiated" charges, an average consumer of

"supplemental" insurance of ordinary intelligence and understanding could objectively interpret and/or reasonably expect the phrase "actual charges" to mean a provider's "billed" or "pre-negotiated" charges.

61. At the time Defendants and its predecessors-in-interest issued and delivered the supplemental cancer insurance policies to Plaintiffs and the members of the Proposed Class, the contracting parties objectively understood, agreed and reasonably expected that in exchange for paying substantial premiums, Plaintiffs and the members of the Proposed Class would enjoy the present right to receive an unlimited amount of insurance coverage measured by the greater, "billed" or "pre-negotiated" charges.

62. Plaintiffs and the members of the Proposed Class have invested, and continue to invest, thousands of dollars to maintain and continue their very lucrative property right to unlimited insurance coverage.

D. IN 2006, DEFENDANT UNILATERALLY *CHANGED* ITS INTERPRETATION OF "ACTUAL CHARGES" FROM A PROVIDER'S GREATER "BILLED" OR "PRE-NEGOTIATED" CHARGES TO THE SUBSTANTIALLY REDUCED "DISCOUNTED" OR "POST-NEGOTIATED" CHARGES A MEDICAL PROVIDER ACCEPTS FROM A "MAJOR-MEDICAL" INSURER IN EXCHANGE FOR PATIENT STEERAGE

63. Starting around May 2006, Defendants decided to disregard the originally intended meaning of "actual charges" and, instead, *unilaterally changed* its interpretation of that term to mean the reduced "discounted" or "post-negotiated" charges" that medical providers accept from their patients' "major-medical" insurer in consideration for patient

steerage. This change often resulted in policyholders receiving ***substantially smaller payouts*** than they would have received under the pre-2006 practice.

64. Defendants' reinterpretation of the pre-existing term "actual charges" was a response to the fact that their supplemental cancer policies had become unprofitable. Previously, in 2002, Defendants "discontinued" the sale of its block of unlimited benefit cancer policies like those issued to Plaintiffs and the members of the Proposed Class because the rising costs and effective use of chemotherapy and radiation therapy caused those policies to be very unprofitable for Defendants.

65. Of course, because these unlimited benefit cancer policies were issued on a "guaranteed renewable" basis, Defendants could not unilaterally cancel them so long as their insureds continued to pay the substantial premiums required to keep them in force.

66. This discontinued block of policies became known by Defendants as their "Discontinued Supplemental Insurance" ("**DSI**") policies.

67. During 2002, Defendants transferred the claims handling function for these DSI policies to its Little Rock, Arkansas operation unit and placed them under financial responsibility and control of executives located in Little Rock, Arkansas.

68. Defendants Little Rock executives made efforts to increase revenue on these unprofitable DSI policies by increasing the premiums required to keep those policies in force. Unfortunately, however, Defendants eventually realized that premium increases alone would not bring these DSI policies back to profitability. This is because the DSI policies fell into

what the insurance industry refers to as a "death spiral." A "death spiral" occurs when the pool of policyholders within a closed block of policies shrinks through attrition while becoming more dense with cancer patients "in claim." When this occurs, the insurer's "loss ratio" on the policies (claims paid ÷ premiums collected) spirals out of control.

69. While the DSI policy death spiral was unprofitable for Defendants, it was economically advantageous for those policyholders who consciously chose to keep their lucrative, unlimited benefit policies in force.

70. So, in 2003, after it realized premium increases alone would never bring its DSI product line back into profitability, Defendant formed a team of senior management officials to study ways to reduce benefits under the DSI policies in order to increase their profitability or at least minimize the company's losses.

71. Because the unlimited, "chemotherapy" benefit was causing much of the unprofitability in the DSI policies, Defendants primarily focused on different ways to reduce benefits payable under that benefit, including excluding coverage for items and treatments that Defendants and its predecessors-in-interest had previously understood to be covered.

72. When it became obvious to Defendants that these new coverage exclusions would not be enough to bring the DSI policies back to profitability, Defendants created what it called the "DSI Task Force" to pursue more aggressive ways to reduce benefits payable under its DSI product line.

73. While Defendants knew or should have known that a person of ordinary intelligence and understanding could reasonably interpret "actual charges" to mean the greater "billed" or "pre-negotiated" charges, the DSI Task Force nevertheless decided to change Defendants' historic interpretation of "actual charges" from the greater, "billed" or "pre-negotiated" charges to the far lesser, "cash-only" amount and they devised new claims handling procedures to implement that changed interpretation.

74. Defendants' change of interpretation immediately impaired the value of the vested property right its DSI policyholders enjoyed and greatly diminished the substantial investment they made to keep those discontinued, unlimited policies in force.

75. Defendants unconvincingly tried to characterize the substantial reduction in benefits as merely a product of "updated" or "corrected" claims procedures rather than a unilateral change of its historic interpretation of "actual charges."

76. Numerous courts have rejected this sophistry and have, instead, recognized that Defendants' so-called "corrected" payment procedures is nothing more than a unilateral change on its part of its historic interpretation of "actual charges."

77. The only policyholders who do not receive substantially reduced coverage under Defendants' changed interpretation of "actual changes" are those policyholders who have not independently bargained to receive "major-medical" insurance coverage or who have such coverage with a carrier that has not negotiated a preferred-provider discount with their particular medical provider.

78. Notably, under Defendants' changed interpretation of "actual charges," policyholders without "major-medical" health insurance still enjoy "supplemental" coverage measured by the "billed" or "pre-negotiated" charges while the coverage of policyholders who have independently bargained to receive "major-medical" insurance is measured by the dramatically reduced "cash-only" portion.

79. Consequently, Defendants' new interpretation of "actual charges" plainly discriminates among similarly-situated insureds in the amount of coverage they presently enjoy.

80. Whereas Defendants used to pay all policyholders the same benefit measured by the "billed" or "pre-negotiated" charges, it now pays each insured a different amount depending solely upon the type of "major-medical" insurance, if any, they have. Under this approach, the larger the preferred-provider discount a policyholder's "major-medical" insurer has negotiated with their provider, the smaller cash benefit they receive under their supplemental cancer policy.

81. Accordingly, pursuant to Defendants' new interpretation of "actual charges", two identically-situated policyholders who are the *same* age, live in the *same* town, pay the *same* premium to maintain the *same* cancer policy, see the *same* doctor, receive the *same* diagnosis, receive the *same* cancer treatment and receive the *same* statement charges in the same *amount* are paid a *different* amount of benefits depending solely upon the nature and extent of any "major medical" insurance they may have.

82. Defendants realized that in order for it to measure actual charge benefits based on the "cash-only" portion that its policyholders' medical provider accepts from an unrelated, "major-medical" insurer, it would have to ascertain what it is not legally entitled to know, that is, the nature, existence and extent of the medical provider's confidential and proprietary steerage arrangement negotiated with a "major-medical" insurer.

83. Ascertaining this confidential information initially posed a conundrum for Defendants. This is because Defendants knew it was not contractually entitled to receive this information. After all, Defendants offered only "supplemental" cancer coverage, which by definition, was supposed to pay cash benefits directly to the insured and "without regard" to any other insurance they may have.

84. Acknowledging that it lacked the contractual right to condition its policy benefits upon disclosure of these third-party "preferred-provider" agreements, Defendants spent months exploring ways to "estimate" or "guess" what "cash-only" portion a medical provider may accept for a particular treatment without having to ask the policyholder directly.

85. Defendants studied the feasibility of estimating the "cash-only" portion by:

a. using the medical pricing information maintained by an internet service provider at www.reimbursementcodes.com;

b. subscribing to a service that maintains information about providers' "usual and customary charges";

c. designing, in-house, a database and computer system to estimate this amount; and even

d. hiring a private investigator to surreptitiously uncover this confidential information.

86. Of course, none of these methods worked, nor would any of them have been lawful. So finally, much to its chagrin, Defendants realized that the only way it could ascertain the "cash-only" portion that providers were accepting from "major-medical" insurance companies was to simply bluff its policyholders into believing they had a contractual obligation to disclose that amount before they could receive the "supplemental" cash benefits for which they bargained.

E. SINCE 2006, COURTS THROUGHOUT THE COUNTRY HAVE UNIFORMLY CONSTRUED THE TERM "*ACTUAL CHARGES*" IN SUPPLEMENTAL CANCER POLICIES, INCLUDING ***DEFENDANTS'*** POLICIES AT ISSUE HERE, TO MEAN A PROVIDER'S GREATER "BILLED" OR "PRE-NEGOTIATED" CHARGES RATHER THAN A PROVIDER'S REDUCED, "DISCOUNTED" OR "POST-NEGOTIATED" CHARGES

(i) Several Courts Have Construed the Meaning of "Actual Charges" in Virtually Identical Cancer Policies Issued by Other Supplemental Insurance Carriers to Mean a Provider's "Billed" or "Pre-Negotiated" Charges

87. Defendants are not the only supplemental insurer to unilaterally change its interpretation of "actual charges" in the wake of the rising cost of cancer treatment. As a result, the meaning of "actual charges" has been vigorously litigated over the last several years.

88. Defendants know that a multitude of cancer policyholders across the country have challenged similar attempts by supplemental cancer insurance carriers to change the historical and intended meaning of "actual charges."

89. Defendants also know that these policyholders have prevailed on this issue in resounding fashion.

90. In fact, Defendants know that almost every court that has ever interpreted the term "actual charges" in like policies has concluded that the term is ambiguous and should be construed in favor of the policyholder to mean a provider's "billed" or "pre-negotiated" charges.

91. Accordingly, Defendants knows or reasonably should know that the legal issue regarding the meaning of the term "actual charges" in its cancer polies has been decided and judicially established to mean the "billed" or "pre-negotiated" charges.

(ii) Three Federal Courts Have Already Entered a Judgment against Defendants That Declares "Actual Charges" Means a Provider's "Billed" or "Pre-Negotiated" Charges

92. The instant suit is one of multiple actions that have been filed against Defendants across the country regarding the interpretation of the term "actual charges" in their supplemental cancer insurance policies. The first action filed, *Gooch v. Life Investors Insurance Co. Of America*, No. 1:07-cv-00016 (M.D. Tenn.2007) ("***Gooch***"'), sought injunctive relief on behalf of a national class. Subsequently, numerous statewide class actions have been brought against Defendants.

93. As a result of this litigation, at least the following three (3) federal courts have entered judgment against Defendants that declare the term "actual charges" means the "billed" or "pre-negotiated" charges:

a. *Lindley v. Life Investors Ins. Co. of Am.*, No. 08-CV-0379-CVE-PJC, 2009 WL 2163513, at *1 (N.D. Okla. July 17, 2009);

b. *Smith v. Life Investors Ins. Co. of Am.*, No. 2:07-cv-681, 2009 WL 3756911, at *8 (W.D. Pa. Nov. 6, 2009); and

c. *Gooch v. Life Investors Insurance Company of Amer*, 264 F. R. D. 340 (M.D. Tenn. 2009).

94. Not a single court has ever construed the term "actual charges" in Defendants' favor.

95. Each of the three, aforementioned federal actions were brought by policyholders insured under a supplemental cancer insurance policy that is substantially identical to the supplemental cancer insurance policies presently maintained by Plaintiffs and the members of the Proposed Class.

96. In each of the three aforementioned federal actions:

a. the precise and central issue in this case–the meaning of "actual charges" –was raised and throughly litigated;

b. the ultimate judgment depended upon an adjudication of the meaning of "actual charges";

c. Defendants had a full and fair opportunity to litigate the meaning of "actual charges";

d. Defendants did, in fact, vigorously litigate the meaning of "actual charges" with extensive documentation and witness testimony;

e. the court entered judgment that was either final on the merits or otherwise "sufficiently firm" to be accorded preclusive effect which declares:

i. the term "actual charges" in Defendants' policies is ambiguous;

ii. that an average insurer covered under such policies would reasonably interpret "actual charges" to mean the "billed" or "pre-negotiated" charges;

iii. Defendants unilaterally changed its interpretation of "actual charges" from the "billed" or "pre-negotiated" charges to the "cash-only" portion; and

iv. the term "actual charges" should be construed in favor of Defendants' insureds and against Defendants to mean the "billed" or "pre-negotiated" charges; and

f. Defendants have or had a financial incentive to settle the litigation because of the entry of these judgments.

F. ON MARCH 6, 2009, THE *GOOCH* COURT RULED THAT DEFENDANTS WAS UNDERPAYING BENEFITS BY USING AN INCORRECT INTERPRETATION OF "ACTUAL CHARGES" AND SIGNALED ITS INTENTION TO CERTIFY A NATIONWIDE CLASS ACTION AGAINST DEFENDANTS ON A LITIGATED BASIS

97. On March 6, 2009 the Honorable Judge Haynes, presiding over the aforementioned *Gooch* case, entered partial summary judgment in favor of the insured and against Defendants that declared that the term "actual charges" in an identical cancer policy means the "billed" or "pre-negotiated" charges. Judge Haynes' order also certified that issue for a class-wide resolution under Fed. R. Civ. P. 23(b)(2) (Ex. 4 at 22-26). The upshot of this combined ruling was that Judge Haynes agreed with the policyholder's interpretation of the insurance policy and intended to grant class-wide relief to all similarly-situated policyholders like Plaintiffs and the members of the Proposed Class.

98. The *Gooch* court, however, promptly vacated this combined ruling to give Defendants additional time to oppose the relief granted. However, Judge Haynes made clear to Defendants that he did not intend to revisit his conclusion as to the meaning of "actual charges."

99. Accordingly, Defendants saw the writing was on the wall in *Gooch*. Given Judge Haynes' initial rulings and Defendants' inability to mount a meritorious defense, Defendants correctly anticipated that Judge Haynes would eventually reinstate his summary judgment and nationwide certification order which would ultimately require Defendants to return to its former practice of measuring "actual charge" benefits in the greater "billed" or "pre-negotiated" charges. But given that such ruling against Defendants would have an estimated Billion dollar impact on its future profits, Defendants was not going to give Judge Haynes the opportunity to reinstate those rulings.

G. BEFORE JUDGE HAYNES IN *GOOCH* COULD REINSTATE HIS CERTIFICATION ORDER THAT WOULD ULTIMATELY REQUIRE DEFENDANTS TO RETURN TO ITS HISTORIC INTERPRETATION OF "ACTUAL CHARGES," DEFENDANTS COLLUDED WITH *RUNYAN* CLASS COUNSEL (WHO WERE OPENLY "ANTAGONISTIC" AND "HOSTILE" TO PLAINTIFFS AND THE MEMBERS OF THE PROPOSED CLASS) TO OBTAIN JUDICIAL APPROVAL OF A COLLUSIVE CLASS SETTLEMENT THOUGH "UNCONTESTED," "SETTLEMENT-ONLY" PROCEEDINGS WHICH PRODUCED A JUDGMENT RENDERED IN VIOLATION OF DUE PROCESS

(I) Defendants Unlawfully Reached a Collusive Settlement Agreement With *Runyan* Class Counsel Whose Financial Interests Were Not Only "Antagonistic" But Also "Outright Hostile" to Plaintiffs and the Proposed Class

100. Given Judge Haynes' inclinations in *Gooch* to certify a class action against Defendants, it scrambled to reach an immediate, nationwide class settlement with a group of lawyers ("***Runyan* Class Counsel**") who had already lost their bid for class certification in a similar case styled *Pipes v. Life Investors Ins. Co. of Am.*, 254 F.R.D. 544, 550 (E.D. Ark. 2008). The *Pipes* court found that they would not fairly and adequately protect the interests of the class. Given that they had been found unfit to represent the interests of the class, *Runyan* Class Counsel found themselves as the least likely lawyers to successfully obtain a class action against Defendants.

101. Seizing upon their weakened position, Defendants made a simple proposal to *Runyan* Class Counsel: Receive an uncontested fee of $3.5 Million dollars just by accepting settlement terms that are exceedingly favorable to Defendants and illusory to its policyholders; or reject those terms and watch the court in *Gooch* award a class counsel fee to someone else.

102. Under these circumstances, neither Defendants nor *Runyan* Class Counsel wanted to give Judge Haynes the opportunity to make Plaintiffs and the members of the Proposed Class whole.

103. With a Billion dollars in future profits at stake for Defendants and a $3.5 million dollar payday waiting for *Runyan* Class Counsel, both parties had a financial interest antagonistic to and in stark conflict with the interests of Plaintiffs and the members of the Proposed Class. To further their own financial interests, *Runyan* Class Counsel helped Defendants mislead and deceive Plaintiffs and the members of the Proposed Class and induced them to become ostensibly bound by a collusive and illusory settlement agreement (the "***Runyan* Settlement**") that was secretly designed to impair the value of their unlimited benefit policies and greatly diminish the significant investment they each made to keep their unlimited coverage in force after all these years.

104. The *Runyan* Settlement provided that Defendants would pay *Runyan* Class Counsel an uncontested fee of $3.5 million for agreeing to the terms of the settlement. As Defendants would benefit from the settlement by limiting its potential exposure to adverse judgments, its goal was to get the *Runyan* court's approval on the Settlement Agreement as quickly and cheaply as possible. That goal could be furthered by creating an incentive for *Runyan* Class Counsel to stop seeking the full measure of their clients' damages in exchange of receiving a lucrative fee of $3.5 million for expending relatively little additional effort-effort that would be aided by their clients' adversary. By *Runyan* Class Counsel agreeing to the

uncontested $3.5 million fee before the *Runyan* action was even filed, *Runyan* Class Counsel had no motivation at any point in that action to engage Defendants in any adversarial manner. Instead, it was in *Runyan* Class Counsel's interest to: (a) stifle objections from the class members they were meant to represent, (b) thwart any other actions that might jeopardize their sizeable fee, and (c) surrender all control over the *Runyan* proceedings.

105. Consequently, *Runyan* Class Counsel's collective interest became aligned with that of Defendants' in every meaningful sense and consequently, they placed their own interests above those of class motions they purported to represent.

106. *Runyan* Class Counsel certainly fulfilled its end of this collusive bargain. While *Runyan* Class Counsel were initially "***antagonistic***" to the interests of Plaintiffs and the members of the Proposed Class, they quickly demonstrated "***outright hostility***" toward them when Judge Haynes in *Gooch* put their $3.5 million payday in jeopardy through reinstatement of his summary judgment and class certification order. Although the rulings in *Gooch* undoubtedly promised to provide their supposed clients far greater relief than the collusive *Runyan* Settlement provided, *Runyan* Class Counsel actively opposed that ruling. Despite the obvious benefits to their clients, *Runyan* Class Counsel opposed the relief of the illusory, *Runyan* Settlement that would award them a $3.5 million fee.

107. There were no *bona fide*, arms-length settlement negotiations between Defendants and *Runyan* Class Counsel.

108. The *Runyan* Settlement was completely finalized before the settling parties agreed to commence the *Runyan* action. Moreover, the *Runyan* action would never have been filed but for the finalization of the collusive settlement and *Runyan* Class Counsel's advance promise to:

a. never contest or litigate any of the present legal and factual disputes between Defendants and its policyholders;

b. never oppose the approval the collusive settlement; and

c. assist Defendants in stifling any opposition to the collusive settlement.

109. The terms of the collusive *Runyan* Settlement are directly contrary to the laws of South Carolina and other states of the country and is further designed to circumvent legislative mandates imposed on Defendants.

110. *Runyan* Class Counsel only commenced the *Runyan* proceedings to further the goals of the parties' collusive agreements and they never would have commenced those proceedings without Defendants' express permission to do so.

111. The *Runyan* Class Action that was filed to initiate the *Runyan* proceedings was actually drafted at the direction, participation and approval of Defendants.

112. Not a single allegation was made in the *Runyan* Class Action Complaint without Defendants' prior approval.

113. The *Runyan* Class Action Complaint was, therefore, a fraud on the judicial system.

114. The settling parties never intended to engage in any *bona fide* litigation of any legal or factual issue and, in fact, the parties promised each other that they would never do so.

115. The entire *Runyan* proceedings constituted a sham action orchestrated by the settling parties to abuse the public trust and impermissibly cause the *Runyan* court to act as a mere superintendent of their collusive, pre-litigation settlement agreement which they intended enforce against absent parties to impair their valuable property rights and contravene their economic interests.

(ii) *Runyan* Class Counsel Promoted a Collusive Class Settlement That Would Immediately Impair the Value of the Unlimited Benefit Coverage Presently Enjoyed by Plaintiffs and the Members of the Proposed Class in Exchange for Nothing but Illusory Consideration

116. Pursuant to the *pre*-suit, *Runyan* Settlement, *Runyan* Class Counsel ostensibly agreed on behalf of Plaintiffs and the Proposed Class to be "permanently barred and enjoined" from challenging Defendants' re-interpretation of the policy term "actual charges".

117. This injunction was designed to substantially impair the value of its policyholders investment made to keep her unlimited benefit coverage in force long after Defendants stopped selling such unlimited insurance products.

118. In exchange for this permanent injunction, Defendants provided nothing to Plaintiffs and the members of the Proposed Class but the illusory promise that it would temporarily refrain from seeking additional premium increases for only a few business days.

119. In the meantime, Defendants were entitled to seek as many premium increases they desired before and after the approval of the *Runyan* Settlement.

120. In short, while the *Runyan* Settlement provided approximately a Billion dollars in future profits to Defendants, it provided nothing to active policyholders like Plaintiffs and the members of the Proposed Class.

(iii) To Facilitate Approval of the Collusive *Runyan* Settlement, *Runyan* Class Counsel Agreed to Abandon Their Federal Litigation in Lieu of Commencing an Uncontested "Settlement-Only" Action in Defendants' Home Town of Little Rock, Arkansas For the Sole Purpose of Avoiding The Consumer Safeguards Established by CAFA

121. With the uncontested fee of $3.5 million waiting for them, *Runyan* Class Counsel began opposing all dissension to the collusive settlement. Instead of proceeding to judgment in any of their pending federal cases against Defendants, *Runyan* Class Counsel worked with Defendants to prevent any such judgment in those cases. Shortly after *Runyan* Class Counsel filed the *Runyan* complaint, they and Defendants jointly moved to stay the federal actions and seek the *Runyan* court's approval of the collusive settlement. This effectively ended the federal actions, clearing the way for Class Counsel to push for approval of the settlement.

122. *Runyan* Class Counsel agreed to seek approval of the collusive settlement in state court because they knew its illusory terms would never pass muster in the federal court

systems, particularly given the substantive and procedural safeguards provided by the Class Action Fairness Act of 2005, 28 U.S.C. §1332(d), 1453 and 1711-1715 ("**CAFA**").

123. Accordingly, on March 13, 2009, *Runyan* Class Counsel filed a new action in the Circuit Court of Pulaski County, Arkansas styled *Edison Runyan, et al. v. Transamerica Life Insurance Company, et al.*, No. CV-09-2066-3 ("***Runyan***") for the sole purpose of bringing about a result in furtherance of the ***Defendants'*** economic interests.

124. The "settlement-only" proceedings in *Runyan* were never contested in "*good faith*," nor were they ever intended to be.

125. Avoiding the adversarial process was something that the *Runyan* Class Counsel actively sought, noting to the *Runyan* court that the *Runyan* case had been brought collectively by the parties solely for settlement purposes and, in their mind, the *Runyan* court was ***not*** the place for "contested" litigation.

126. Defendants' lead counsel in the *Runyan* action made similar admissions in open court that no litigation was ever intended to occur within that proceeding. Counsel also confirmed under oath that the *Runyan* Settlement was reached on March 3, 2009, ***before*** the *Runyan* Complaint was even filed. This statement was confirmed by *Runyan* Class Counsel who independently conceded that the substantive settlement occurred ***before*** their filing of the complaint in state court.

127. Throughout the *Runyan* proceedings, there were repeated instances where *Runyan* Class Counsel allowed Defendants to conduct the entire proceeding. For example, in the April 23, 2009 hearing for preliminary approval of the pre-filing settlement, lead counsel

for Defendants presented the settlement, argued for its initial approval, and asked for the class to be certified ***with no meaningful involvement from Class Counsel***, other than his indication of his agreement for preliminary approval. The entire hearing for preliminary approval lasted just long enough to fill twelve (12) pages of transcript. *Runyan* Class Counsel spoke just enough to fill one (1) page of that transcript.

128. From the inception of the *Runyan* settlement action, the only discernible effort exerted by *Runyan* Class Counsel was to initiate the suit (which only they alone could do and which they did by virtue of their agreement with Defendants), in exchange for a $3,500,000 attorney fee.

(iv) *Runyan* Class Counsel and Defendants Colluded to Deceive Plaintiffs and the members of the Proposed Class and Fraudulently Induced Them Not to Exclude Themselves From the *Runyan* Proceedings They Knew Would Violate Their Due Process Rights

129. During the spring of 2009, Defendants issued a Class Action Settlement Notice (the "**Notice**") regarding the *Runyan* Settlement.

130. The Notice included a description of 'non-monetary benefits' that policyholders would receive if they did not opt out. According to the description, one benefit would be that, in the future, "actual charges" would be construed as "the amount legally owed to the provider". This would be a "benefit," the Notice stated, because the parties "expected" it would lessen "the amount and frequency of future premium increases." In the same paragraph, the Notice falsely represented that this construction of "actual charges" was consistent with

'current' South Carolina law. The Notice also falsely suggested that Defendants had viable ***"claims or counterclaims*** for overpayment of benefits" against its policyholders.

131. However, given the numerous court decisions that had previously settled the meaning of actual charges in cancer policies, including Defendants' own cancer policies, when the parties drafted and mailed the Notice, they knew that Defendants' policyholders were not liable to Defendants for any overpayment, but instead really knew they were legally entitled to 100% of the disputed benefits.

132. The Notice was further incomplete and materially *misleading* insofar as it failed to disclose that:

a. a multitude of courts, noted *supra*, had already construed "actual charges" in their favor;

b. Defendants' proposed interpretation of "actual charges" was the total opposite of the interpretation it used when they purchased their policy;

c. courts of most, if not all, states including South Carolina would construe any ambiguity in "actual charges" against Defendants; and

d. the South Carolina statute upon which the proposed definition of actual charges was predicated did not and constitutionally could not apply to their policies.

133. Moreover, the Notice language made the deceptive and misleading threat if they did not agree to the settlement they would expose themselves to a lawsuit for "**overpayment of benefits that the Company might otherwise have against any Settlement Class Member . . .**"

134. Also the Notice gave the false impression that Defendants had stopped seeking rate increases for the year 2009 and misrepresented that it would abide by the terms of the *Runyan* Settlement, including the promise in that "the Final Order and Judgment will contain a provision enjoining the Company from" applying for or seeking "any premium rate increases". The final judgment in *Runyan* did not contain the promised injunction against Defendants nor did the settling parties ever intend it do so.

135. The Notice's language created an impression that policyholders who had purchased a policy prior to June 4, 2008, were not entitled to any relief and, therefore, could not possibly receive any greater benefit from litigation than the "benefits" of the settlement, which included a non-committal prediction of low, infrequent increases in premiums. Conversely, it was further designed to mislead policyholders that if they "opted out" they may be sued and actually lose money. In effect, the Notice said to policyholders, "stay in the settlement and take money to which you're not entitled, or opt-out, take nothing, and risk getting sued and losing money."

136. The Notice was, therefore, purposefully designed to misinform Plaintiffs and the members of the Proposed Class concerning the value of their rights if they opted out and the relative value of remaining in the settlement. As such, the Notice was materially misleading and the *Runyan* court's exercise of jurisdiction over them violated their due process rights.

137. *Runyan* Class Counsel specifically denied that the Notice was defective. Instead, they argued in favor of a settlement agreement that would allow Defendants to pay

policyholders less than half of what they were owed under applicable law, while *Runyan* Class Counsel would receive an attractive sum.

(v) *Runyan* Class Counsel Approved a One-Sided Disclosure Requirement that Required Misinformed, Policyholders to Disclose All Their Factual and Legal Grounds for Opposing the *Runyan* Settlement but Protected the Settling Parties From Having to Identify or Disclose Anything in Support of the Alleged "Reasonableness" of that Settlement

138. Rather than merely requiring an objector to fill out a standard objection form, *Runyan* Class counsel actually approved and encouraged a procedure that gave class members (most of whom were elderly people, many with cancer) little over a month to marshal every fathomable basis they could think of to oppose the terms of a settlement agreement they knew nothing about. The Notice actually required these elderly people to provide a detailed brief that contained a description of the ***nature and all grounds*** for the objection, including ***any legal support*** intended to introduce or present in support of their objection, including:

i. a detailed statement of the specific legal and factual basis for each ground for objection;

ii. a list of any witnesses that the Objector would like to call at the Fairness Hearing, with the address of each witness and a summary of his or her proposed testimony;

iii. a detailed description of any and all evidence the Objector may offer at the Fairness Hearing, including copies of any and all exhibits which the Objector may seek to introduce at the Fairness Hearing;

iv. an immediate commitment as to whether they intended to travel from their home state to Arkansas for purposes of appearing at the scheduled Fairness Hearing either in person or through counsel; and

v. the identity of any attorney they were going to have appear with them or on their behalf.

139. According to the *Runyan* court, any challenge to the settlement would be constrained to any policyholder allowed to appear at the fairness hearing and to the four-corners of their written brief - an objector was not allowed to utter a single legal or factual position not initially raised therein. In other words, the objector could, in essence, only read their written objection on the record. Of course, the settling parties were not constrained in any such way.

140. To further frustrate their ability to mount any meaningful opposition to the settlement, Defendants and *Runyan* Class Counsel actively thwarted absent class members' ability to discover in advance any witnesses, exhibits or legal authority the settling parties would rely upon in support of the proposed settlement.

141. The *Runyan* proceedings failed to satisfy the minimum procedural requirements of the Fourteenth Amendment's Due Process Clause.

142. The *Runyan* proceedings did not afford absent class members with a opportunity to appear and be heard regarding the proposed settlement that satisfied the minimum procedural requirements of the Fourteenth Amendment's Due Process Clause.

143. Absent class members like Plaintiffs and the members of the Proposed Class were not aware and was never informed by *Runyan* Class Counsel that the *Runyan* Settlement was collusive.

144. Plaintiffs were not aware and was never informed by *Runyan* Class Counsel that she had a legal right to have that ambiguous term "actual charges" liberally construed in her favor nor was she told that federal courts throughout the country had previously entered judgment against Defendants that declared the identical term "actual charges" in her favor.

145. Plaintiffs and the members of the Proposed Class were not named parties to the *Runyan* proceedings.

H. ON DECEMBER 21, 2009 BOTH THE COURTS IN *GOOCH* AND *RUNYAN* ENTERED CONTRADICTORY CERTIFICATION ORDERS

(i) The *Runyan* Judgment Certified an "Uncontested," Settlement-Only Class That Provided Illusory Relief to the Class

146. The *Runyan* court held a fairness hearing on November 9, 2009.

147. During that hearing, the *Runyan* court, at the urging of Defendants and *Runyan* Class Counsel, refused to allow objectors call witnesses in support of their objections.

148. Defendants and *Runyan* Class Counsel also colluded with each other by agreeing that neither of them would call a single witness during the hearing so that objectors would not be able to cross-examine them.

149. Absent class members were not provided the opportunity to object and to appear at the fairness hearing in connection with the *Runyan* Settlement.

150. Defendants and *Runyan* Class Counsel also colluded with each other by agreeing not to disclose any evidence they intended to rely upon to support the collusive settlement before the hearing.

151. Instead, the settling parties waited until one or two business hours before the fairness hearing to file all of their evidence with the Clerk of the *Runyan* court and did not give any of the objectors notice of those filings until after the hearing was over.

152. *Runyan* Class Counsel did so for the sole purpose of preventing objectors-people they were supposed to represent-from having a fair opportunity to challenge or rebut the sufficiency of their evidence.

153. Unfortunately, the *Runyan* court did nothing to discourage the parties' collusive conduct. In fact, the court had all orders and opinions entered in the *Runyan* case drafted by Defendants' counsel, who without the consent of any representative for the absent class members, drafted those orders to include findings of fact that were unsupported by the actual record and evidence and that made conclusions of law plainly inconsistent with the United States Constitution.

154. Defendants also drafted the *Runyan* Judgment which, on December 21, 2009, certified a nationwide class of policyholders for purposes of approving the collusive *Runyan* Settlement, an agreement that provides Plaintiffs and the members of the Proposed Class with absolutely nothing but, instead, immediately divests them of the present value of their cancer insurance coverage.

155. Moreover, the *Runyan* Judgment presently and permanently enjoins Plaintiffs from enforcing their present contractual rights by precluding her from "filing, commencing, prosecuting, intervening in, or participating in (individually or in a representative capacity) any lawsuit, action, or proceeding in any jurisdiction asserting or based upon any claims or causes of action released in the Settlement and this Final Judgment".

156. Moreover, the *Runyan* Judgment further presently deprives Plaintiffs of their First Amendment right to free speech and assembly by permanently barring and enjoining her from "organizing, soliciting, or encouraging any other Class members to participate in any such lawsuit, action, or proceeding".

157. Contrary to the terms of the *Runyan* Settlement, the *Runyan* Judgment did not enjoin Defendants from doing anything. In particular, it failed to enjoin Defendants from applying for or seeking "any premium rate increases" as the *Runyan* Settlement required.

158. The reason the *Runyan* Judgment–drafted by Defendants– excluded this promised premium injunction is obvious. The inclusion of that injunction would only have highlighted the illusory nature of the Defendants' purported consideration for the settlement.

159. Given that the *Runyan* Settlement was not approved until December 21, 2009, Defendants was only required to refrain from seeking premium rate increases for only 5 or 6 business days. For that illusory promise, Defendants obtained approximately a Billion dollars in future profits.

160. So, even though the *Runyan* Settlement required inclusion of this 5 or 6 day premium injunction in the *Runyan* Judgment, Defendants, with *Runyan* Class Counsel's approval, intentionally omitted that provision from the judgment in order to conceal the collusive, illusory nature of the settlement.

161. The *Runyan* Court did not "adjudicate" a single legal or factual dispute among Defendants and its policyholders. It merely approved the parties' collusive settlement.

162. Accordingly, the *Runyan* court did not, and could not have, adjudicated the meaning of "actual charges" or any other legal or factual issue raised in instant case.

163. Since the day the *Runyan* Judgment was first entered on December 21, 2009, Defendants has repeatedly and judicially admitted in courts throughout the country, including in this action, that the *Runyan* Judgment constitutes a "final" judgment.

164. The Arkansas judicial system has no important state interest in protecting or enforcing judgments which, like the *Runyan* Judgment, are rendered in violation of the Due Process Clause of the Fourteenth Amendment.

(ii) The *Gooch* Judgment Certified a Class on a Litigated Basis that Provides Full Recovery to Defendants' Policyholders

165. On December 21, 2009, the same day that the *Runyan* court entered the *Runyan* Judgment prepared by Defendants, the *Gooch* court published an opinion that reinstated its prior order granting class certification against Defendants and declared the term "actual charges" to mean the "billed" or "pre-negotiated" charges.

166. Accordingly, unlike the *Runyan* Judgment which provides nothing to Plaintiffs and the members of the Proposed Class, the *Gooch* Judgment allowed them to preserve the value of their present insurance coverage and recover 100% of what they were owed.

167. Under well-settled law, the *Gooch* certification order should have controlled because it was the last decision entered, albeit only by a matter of hours.

I. *RUNYAN* CLASS COUNSEL ACTUALLY OPPOSED ITS CLIENTS' OBVIOUS FINANCIAL INTEREST IN RECEIVING FAR GREATER RELIEF AWARDED BY THE COURT IN *GOOCH* FOR THE SOLE PURPOSE OF PROTECTING THEIR OWN FINANCIAL INTEREST IN RECEIVING A FEE OF $3.5 MILLION

168. In January 2010, two class members who had previously attempted unsuccessfully to intervene filed a motion asking the *Runyan* court to reconsider the *Runyan* Judgment in light of the *Gooch* order that had been issued the same day.

169. In a January 19, 2010, hearing on this motion, *Runyan* Class Counsel, along with Defendants, argued against the class receiving the full relief awarded in *Gooch*.

170. Accordingly, *Runyan* Class Counsel actually objected to the requested reconsideration even though their supposed clients would have benefitted much more in the *Gooch* case than they would ever receive under the collusive *Runyan* Settlement.

171. *Runyan* Class Counsel's conduct in opposing the classes' ability to be made whole by *Gooch* reconsideration approached ***outright hostility*** to the *Runyan* class members. Rather than seizing on the opportunity to obtain greater sums for their clients through *Gooch*, *Runyan* Class Counsel continued to advocate an outcome that, in all likelihood, would be ***substantially less lucrative*** for their client. Significantly, one *Runyan* Class Counsel member

argued against reconsideration on the merits, and he further argued that the class members lacked standing to bring the motion. Part of the reason these two class members lacked standing is that *Runyan* Class Counsel argued against their motions to intervene. In fact, having successfully opposed all attempts to intervene, *Runyan* Class Counsel and the class representatives were the only ones who had standing to seek a more favorable result for the class. Furthermore, they were the only ones with both the duty and the opportunity to advocate for the class. Instead of taking that opportunity, they vigorously opposed it. In other words, *Runyan* Class Counsel argued against their clients recovering 100% of they were owed. The only plausible motivation for such conduct is the $3.5 million fee that *Runyan* Class Counsel expected to receive.

172. There are no post-judgment proceedings remaining in *Runyan* for the Arkansas courts to administer.

VI.
CLASS ALLEGATIONS

Plaintiffs incorporate all of her prior allegations herein by reference.

173. Membership of the Proposed Class includes thousands of people dispersed throughout South Carolina and the United States, and, therefore, joining all members of the classes into a single action would be impracticable. The members of the Proposed Class are all known to Defendants and can be provided notice of the pendency of their action through standard U.S. mail.

174. The questions of law and fact to be answered by way of this action are common to each member of the Proposed Class. The common questions to be answered are whether:

a. the undefined phrase "actual charges" within the meaning of Defendants' guaranteed renewable cancer policies should be legally construed to mean a provider's greater "billed" or "pre-negotiated" charges or a provider's reduced "discounted" or "post-negotiated" payments accepted from another "major-medical" insurer in exchange for patient steerage;

b. the *Runyan* Judgment is entitled to Full Faith & Credit, violates the First and Fourteenth Amendments, and otherwise operates as *res judicata* of the claims asserted in this case by Plaintiffs and on behalf of the members of the Proposed Class;

c. Defendants knew or should have known, the undefined phrase "actual charges" was ambiguous and that their policyholders would reasonably expect those terms to mean a provider's greater "billed" or "pre-negotiated" charges;

d. Defendants can legally reduce the amount of benefits otherwise payable under its guaranteed renewable cancer policies based upon an independent steerage agreement negotiated by and between a provider and another, unrelated insurance carrier or plan;

e. whether Defendants fraudulently deceived and induced Plaintiffs and the members of the Proposed Class not to exclude themselves from the *Runyan* class settlement;

f. Defendants breached their contractual obligations to Plaintiffs and the members of the Proposed Class by underpaying them benefits based upon an incorrect interpretation of "actual charges";

g. Defendants breached their duty to treat Plaintiffs and the members of the Proposed Class fairly and in good faith by paying their cash benefits based upon the amount of the reduced "discounted" or "post-negotiated" payments their provider's accepted from another "major-medical" insurer in exchange for patient steerage; and

h. Defendants' reinterpretation of "actual charges" caused it to unlawfully discriminate among its policyholders in the terms of coverage and benefits.

175. The questions of law and fact that are common to Plaintiffs and the members of the Proposed Class predominate over any individualized inquiry that might be required. There are likely no disputed factual issues and the few disputed legal issues will be resolved without the participation of the individual members of that class. The claims of Plaintiffs and the members of the Proposed Class do not present any individualized questions of causation or reliance. Rather, the manner in which Defendants interpreted the term "actual charges" as used in its standardized cancer policies to reduce the amount of benefits otherwise payable thereunder *is* common to the Plaintiffs and the members of the Proposed Class. Moreover, the resolution of the factual and legal issues presented herein will resolve Defendants' alleged liability to Plaintiffs and the members of the Proposed Class. Likewise, damages will also be similar to and ascertainable on a class-wide basis by resolving these common questions applicable to the entire the Proposed Class. Given the large number of members of the Proposed Class and the common issues of law and fact, a class action is superior to other means of resolution with respect to considerations of consistency, economy, efficiency, fairness and equity, as compared to other available methods for the fair and efficient adjudication of this controversy.

176. The claims of Plaintiffs and the members of the Proposed Class and Defendants' defenses thereto, are typical of the claims and defenses applicable to Plaintiffs and the members of the Proposed Class. The theories of recovery of Plaintiffs and the members of

the Proposed Class have the same essential elements and characteristics. Moreover, Defendants' course of conduct giving rise to Plaintiffs' claim is the same course of conduct that gives rise to the claims of all the members of the Proposed Class. Defendants promised to pay Plaintiffs and the members of the Proposed Class benefits measured by their provider's "actual charges." The meaning of that promise is same to Plaintiffs and the members of the Proposed Class.

177. Plaintiffs will adequately represent the members of the Proposed Class. Plaintiffs interests do not conflict with the interests of the members of the Proposed Class, and they and their qualified and experienced counsel are committed to fairly and adequately representing and protecting their interests.

178. Prosecuting separate actions by or against individual class members would create a risk of (A) inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for Defendants; or (B) adjudications with respect to individual class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests.

179. Defendants have acted or refused to act on grounds that apply generally to the members of the Proposed Class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.

180. The questions of law and fact that are common to Plaintiffs and members of the Proposed Classes predominate over any individualized inquiry that might be required. There

are likely no disputed factual issues and the few disputed legal issues will be resolved without the participation of the individual members of that class. Plaintiffs' claims do not present any individualized questions of causation or reliance. Rather, the manner in which Defendants are now interpreting the term "actual charges," "charges" or other synonomous terms used within its supplemental cancer policies to reduce the amount of benefits otherwise payable thereunder is common to the Plaintiffs and the members of the proposed subclasses. Moreover, the resolution of the factual and legal issues presented herein will resolve Defendants' alleged liability to Plaintiffs and all members of the Proposed Class. Likewise, damages will also be similar to and ascertainable on a class-wide basis by resolving these common questions applicable to the members of the Proposed Class. Given the large number of members of the Proposed Class and the common issues of law and fact, a class action is superior to other means of resolution with respect to considerations of consistency, economy, efficiency, fairness and equity, as compared to other available methods for the fair and efficient adjudication of this controversy.

VII.
THEORIES OF RECOVERY

A. FIRST CLAIM: DECLARATORY RELIEF

Plaintiffs incorporate all of her prior allegations here by reference.

181. Plaintiffs seek a declaratory judgment pursuant to 28 U.S.C. § 2201 for herself and the members of the Proposed Class.

182. Plaintiffs and the members of the Proposed Class currently maintain a "supplemental" cancer insurance policy administered by Defendants that promises to pay some benefits in the amount of their provider's "actual charges."

183. The supplemental cancer policies were issued by Defendants on a "guaranteed renewable" basis to Plaintiffs and the members of the Proposed Class.

184. Accordingly, Plaintiffs and the members of the Proposed Class have a present right to enjoy the full value of the supplemental cancer insurance coverage they bargained for.

185. The Plaintiffs and the members of the Proposed Class have paid significant premiums to keep their coverage in force under their supplemental cancer policies in full force and effect.

186. Because the coverage issued to Plaintiffs and members of the Proposed Class were on a "guaranteed renewable" basis, Defendants cannot terminate their policies.

187. Defendants know that policies are valuable to Plaintiffs and the members of the Proposed Class and unprofitable to Defendants.

188. Defendants would terminate the policies of the Plaintiffs and members of the Proposed Class were they not issued on a "guaranteed renewable" basis because Defendants has an economic interest to do so.

189. Likewise, it is in the economic interests of Plaintiffs and the members of the Proposed Class to keep their unlimited benefit Policy in force and they have a legally protected interest in doing so.

190. Plaintiffs and members of the Proposed Class have or may be positively diagnosed with cancer and have and may receive cancer treatment that will require Defendants to pay them cash benefits cash benefits measured in the amount of their providers' "actual charges".

191. Defendants have caused the Plaintiffs and members of the Proposed Class to suffer injury by actively colluding with *Runyan* Class Counsel to immediately, presently, and permanently invade and impair her legally protected interests to keep her unlimited benefit Policy in full force and effect by obtaining approval of a collusive and illusory class settlement agreement through proceedings that violated her due process rights.

192. The *Runyan* Judgment rendered in violation of the due process rights of Plaintiff and the members of the Proposeed Class purports to immediately and permanently enjoin Plaintiffs from not only enforcing her pre-existing contractual rights but also from exercising her protected, First Amendment right to speech and assembly.

193. This Court can remedy the injury caused by Defendants' improper and collusive conduct by granting her the declaratory relief requested herein and preventing Defendants' unlawful discrimination among its policyholders.

194. Accordingly, there currently exists between the parties an actual case and controversy concerning:

a. the meaning of the policy term "actual charges" within the of Defendants' "supplemental" cancer insurance policies; and

b. whether the *Runyan* Judgment, including its present, immediate and permanent injunction against Plaintiffs, is entitled to Full Faith & Credit,

violates the First and Fourteenth Amendments and otherwise operates as *res judicata* of the claims asserted in this case by Plaintiffs and on behalf of the members of the Proposed Class.

195. Plaintiffs do not ask this Court to review the *Runyan* court's determination that the *Runyan* settlement was fair and reasonable, she does not want this Court to reverse any aspect of the *Runyan* Judgment and she certainly does not ask this Court to enjoin the *Runyan* proceedings (which have already concluded) in any fashion.

B. SECOND CLAIM: FRAUD

Plaintiffs incorporate all of her prior allegations here by reference.

196. Defendants knowingly, intentionally and/or recklessly made material and false representations and actively concealed facts regarding the true nature of the claims, issues, defenses, negotiations and representation in the *Runyan* proceedings in order to induce Plaintiffs and the members of the Proposed Class not to exclude themselves from those proceedings and to be unwittingly bound by a collusive settlement agreement that was designed to deprive them of present, fixed and valuable contractual rights and to circumvent the relief they would have otherwise been entitled to receive.

197. Defendants knowingly, intentionally and/or recklessly concealed and omitted material information from Plaintiffs and the members of the Proposed Class that would have caused them to exclude themselves from the *Runyan* proceedings and prevent being bound by the collusive settlement had that information not been concealed or omitted.

198. Defendants knowingly and/or intentionally secured execution of a document by deception which affects the pecuniary interests of Plaintiffs and the members of the Proposed Class.

199. Defendants made promises of future performance to Plaintiffs and the members of the Proposed Class with an intent not to perform as promised.

200. Defendants knew their representations were false and knew they were actively concealing material information and/or made those representations recklessly without the knowledge of the truth and as a positive assertion.

201. Defendants made their material misrepresentations, omissions and concealed facts with the intent to deceive Plaintiffs and the members of the Proposed Class and with the intent that they should act upon the same.

202. Plaintiffs and the members of the Proposed Class reasonably acted in reliance on Defendants' representations, omissions and active concealment.

203. Plaintiffs and the members of the Proposed Class suffered injury as a proximate result of acted in reliance upon Defendants' representations, omissions and active concealment.

204. Defendants' conduct was willful, malicious, fraudulent and/or grossly negligent.

C. THIRD CLAIM: UNJUST ENRICHMENT

Plaintiffs incorporate all of her prior allegations here by reference.

205. Plaintiffs and the members of the Proposed Class conferred a non-gratuitous benefit on Defendants and have advanced monies to Defendants with the reasonable

expectation that Defendants would properly honor their coverage and pay their insurance benefits according to the terms and conditions of their respective policies.

206. Instead, Defendants have intentionally withheld from Plaintiffs and the members of the Proposed Class insurance benefits by paying their actual charge claims based upon the "discounted" or "pre-negotiated" payments their provider's accept from another insurer in exchange for patient steerage instead of the "billed" or "pre-negotiated" charges. Thus, Defendants realized value from the benefits they receveived from Plaintiffs and the members of the Proposed Class.

As a result, Defendants presently holds monies that in good conscious and equity belong to Plaintiffs and all members of the Proposed Class, and it would be unequitable for Defendants to retain the benefit without paying value for same. Moreover, Defendants would be unjustly enriched if allowed to retain said monies, and as a result, should be ordered to repay the same.

D. FOURTH CLAIM: BREACH OF CONTRACT

Plaintiffs incorporate all of her prior allegations here by reference.

207. The supplemental cancer policies of Plaintiffs and the members of the Proposed Class are valid and enforceable contracts.

208. At the time Plaintiffs and the members of the Proposed Class and Defendants entered into their contractual obligations under the policies, they agreed, understood ad reasonably expected that the term "actual charges" was intended to meant a provider's "billed" or "pre-negotiated" charges.

209. The policy phrase "actual charges" is a material term of the policies and is inexplicably intertwined with the cash benefits payable thereunder.

210. Defendants repudiated their obligations under the polices by unequivocally declaring their intention to refuse to pay "actual charge" benefits based on the billed charges and it otherwise disclaimed and failure to perform its contractual obligation to do so, and is thus in breach of its promise to pay "actual charge" benefits based on parties' original and agreed definition of that term.

211. Defendants have no just excuse for refusing to honor their promise to pay "actual charge" benefits based on the billed charges.

212. Defendants' breach of the its promise to pay "actual charge" benefits based on the amount of the provider's "billed" or "pre-negotiated" charges bill substantially impairs the value of the policy for which Plaintiffs and the members of the Proposed Class are continuing to pay substantial premiums.

213. As a result of Defendants' breach, Plaintiffs and members of the Proposed Class have suffered damages.

E. FIFTH CLAIM: BAD FAITH

Plaintiffs incorporate all of her prior allegations here by reference.

214. Defendants knowingly and intentionally underpaid and/or breached their contract with Plaintiffs and the members of the Proposed Class as a matter of routine business practice.

215. Defendants breached its duty to deal fairly and act in good faith towards Plaintiffs and the members of the Proposed Class.

216. As a proximate result of Defendants' breach of its duty of good faith and fair dealing, Plaintiffs and the members of the Proposed Class have suffered aggregate damages and other loss in excess of $5,000,000.00.

217. Defendants have acted intentionally and with malice towards others or has been guilty of reckless disregard for the rights of others entitling Plaintiffs and the members of the Proposed Class to punitive damages.

218. Defendants knew but intentionally disregarded the fact that the policy phrase "actual charges" in their cancer policies means a provider's "billed" amount.

219. Alternatively, Defendants knew but intentionally disregarded the fact that the policy phrase "actual charges" as well as other policy language is ambiguous insofar as said language is reasonably susceptible to more than one interpretation, and otherwise, that the policy phrase "actual charges" could be reasonably interpreted to mean a provider's greater "billed" or “pre-negotiated” charges rather than the reduced “discounted” or “post-negotiated” payments a provider accepts from another insurer in exchange for patient steerage.

220. Rather than liberally construing the ambiguous policy language in favor of the reasonable expectations of Plaintiffs and the members of the Proposed Class, as the law requires, Defendants instead, unreasonably, strictly and narrowly construed that ambiguous policy phrase in its own favor.

VII.
PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on behalf of THEMSELVES and the members of the Proposed Class, pray for judgment against Defendants for the following relief:

a. certification of the Proposed Class for purposes of the adjudicating the claims asserted herein on a class-wide basis;

b. appointment of Plaintiffs' counsel as counsel for Proposed Class;

c. a declaratory judgment that the *Runyan* Judgment is not entitled to Full Faith & Credit, violates the First and Fourteen Amendments, and otherwise does not operate as *res judicata* of the claims asserted in this case by Plaintiffs and on behalf of the members of the Proposed Class;

d. a declaratory judgment that the terms "actual charges", "charges" or other synonomous terms used in Defendants' supplemental cancer insurance policies means a provider's greater "billed" or "pre-negotiated" charges;

e. restitution against Defendants, including, but not limited to, unpaid benefits, unjustly received premiums and/or contractual interest on benefits owed;

f. restitution against Defendants for general, special and exemplary damages in excess of the Court's jurisdictional amount;

g. compensatory damages in excess of $75,000.00 against Defendants;

h. punitive damages;

i. prejudgment and post judgment interest on all damages;

j. costs including but not limited to court costs, expert fees, attorney's fees and expenses; and

k. such other and further relief as the Court deems appropriate under the circumstances presented.

VIII.
JURY DEMAND

Plaintiffs request that a jury be convened to try the factual issues in this case.

Respectfully Submitted,

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