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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

AMANDA K. HORTON; and KEITH ALSTRIN, Plaintiffs, v. USAA CASUALTY INSURANCE COMPANY, a foreign insurer; UNITED SERVICES AUTOMOBILE ASSOCIATION, a foreign intrainsurance exchange; USAA GENERAL INDEMNITY COMPANY, a foreign insurer, USAA COUNTY MUTUAL INSURANCE CORPORATION, a foreign insurer; and GARRISON INSURANCE COMPANY, a foreign insurer, Defendants.	No. CV06-2810 PHX DGC **AMENDED COMPLAINT**

For their Amended Complaint against Defendants, Plaintiffs for themselves and all others similarly situated allege the following:

PARTIES JURISDICTION AND VENUE

1. At all times relevant hereto, Plaintiff Amanda K. Horton ("Horton") was and remains a resident of Maricopa County, Arizona.

2. At all times relevant hereto, Plaintiff Keith Alstrin ("Alstrin") was and remains a resident of Maricopa County, Arizona.

3. At all times relevant hereto, Defendant USAA Casualty Insurance Company (hereafter "USAA CIC") was and is a foreign insurer licensed to transact and transacting insurance business in the state of Arizona and other states.

4. At all times relevant herein, Defendant United Services Automobile Association was and is a reciprocal interinsurance exchange organized under the laws of Texas, licensed to transact and transacting insurance business in the state of Arizona and other states.

5. At all times relevant hereto, Defendant USAA General Indemnity Company was and is a foreign insurer organized under the laws of Texas, licensed to transact and transacting insurance business in the state of Arizona and other states.

6. At all times relevant hereto, Defendant USAA County Mutual Insurance Company was and is foreign insurer organized under the laws of Texas.

7. At all times relevant herein, Defendant Garrison Insurance Company was and is a foreign insurer organized under the laws of Texas. Defendants, their parents, affiliates, and/or subsidiaries are hereafter collectively referred to as "USAA."

8. USAA was and is engaged in the marketing, sale, and issuance of automobile insurance policies in the state of Arizona and other states.

9. This Court has original jurisdiction of the claims asserted herein pursuant to the Class Action Fairness Act and U.S.C. § 1332(d)(2)(A) in that the amount in controversy and the claims at issue exceed the sum of $5,000,000, exclusive of interest and costs, and is a putative class action in which members of the class of plaintiffs are citizens of States different from Defendants' state of citizenship.

10. Venue is proper in this Court pursuant to 28 U.S.C. § 1391. USAA does substantial business in this District, and USAA transacts business, maintains agents or representatives in, or is found in this District. USAA regularly and continuously conducts business in interstate commerce that is carried out in part in this District.

ALLEGATIONS COMMON TO ALL COUNTS

11. Defendants offered and sold a form of first-party medical coverage that provides payment to covered persons for necessary and appropriate health care expenses for bodily injury resulting from a covered automobile accident. This coverage is commonly referenced as Medical Payments ("Med Pay") coverage.

12. Defendants also offered and sold pursuant to certain state statutes or regulations another form of first-party medical coverage called First Party Benefit or Personal Injury Protection ("PIP") that provides payment to covered persons for reasonable and necessary health care expenses incurred as a result of bodily injury resulting from a covered automobile accident.

13. Defendants offered Med Pay and statutorily required PIP coverage to their insureds in states across the country, including offering Med Pay coverage in Arizona.

14. Upon information and belief, USAA contracted with a third party provider, Concentra Integrated Services, Inc., doing business as Auto Injury Solutions or its parents, subsidiaries, or affiliates (collectively referred to as "AIS"), to provide medical bill audit services for review of provider charges submitted on Med Pay and PIP claims. Upon information and belief, AIS employs a computer software program to determine the amount paid for submitted charges for medical, dental, and other health care treatments.

15. Upon information and belief, the software and/or audit process makes two types of reductions that are relevant to the claims here.

16. First, the software unilaterally and arbitrarily reduces the amount paid on medical, dental, and other health care provider bills based upon a determination that the amounts billed are not "reasonable."

17. Upon information and belief, the software program uses unidentified data to link like charges for services of other similar providers in an insured's general geographic area.

18. The effect of such a program is to arbitrarily generate an allowed amount for charges for given geographical locations.

19. The system employed by Defendants and/or their agents categorically eliminates, abates, and/or reduces charges actually incurred above a selected percentile level.

20. Defendants' system is based, rather, upon a statistical model and program, the data for which remains secret and confidential.

21. Under the policies, Defendants have assumed the responsibility and obligation to determine and pay all medical expenses which are "reasonable."

22. Defendants are aware that Plaintiffs Horton and Alstrin, and people similarly situated, could and would be balance billed by providers whose bills were automatically reduced by Defendants' medical bill audit program and, particularly, based on the database determination of a "reasonable" fee.

23. What constitutes a "reasonable" medical expense is a factor of individual medical needs, technical expertise and experience of the involved health care providers, and community standards for billing like services and products.

24. The system employed by Defendants and their agents necessarily diminishes or eliminates the individual character of health care services and concomitant expense, by establishing and utilizing a statistical cost mean as a basis for the denial of medical payments benefits beyond a predetermined deviation therefrom.

25. Defendants assumed the responsibility to determine that expenses were reasonable yet denied certain expenses incurred by Plaintiff Horton and other putative class members as unreasonable, without the requisite expert health care opinion.

26. Defendants' program, at best, may incite inquiry into the reasonableness of various medical expenses, but cannot, perforce, constitute the singular determination

thereof or be a substitute for the weighing and evaluation of the individual components of what constitutes a reasonable healthcare expense.

27. Notwithstanding the limitations of Defendants' program to adjudicate reasonable health care costs and expenses, it has been and is being applied in a manner to systematically eliminate payments for costs beyond a predetermined, statistical mean in given geographic regions.

28. Second, upon information and belief, AIS or its agents have secured or established contractual relationships with health care providers in different geographic areas by which those providers have agreed to be reimbursed at predetermined amounts for healthcare services rendered to patients insured by certain clients of AIS.

29. These agreements are often called preferred provider organization (PPO) or preferred provider network (PPN) agreements. Pursuant to these agreements, the providers agree to accept reduced amounts compared to their usual and customary charges for procedures in exchange for being a participant in a preferred provider network.

30. Upon information and belief, Defendants, who have no direct agreements with medical, dental, or other health care providers, wrongfully utilize the PPO and PPN agreement contracted rates that AIS or its agents have secured or established with certain providers in order to reduce the amounts that Defendants will reimburse their insureds or pay on behalf of their insureds under the Med Pay and PIP coverages.

31. Defendants do not inform their insureds or the healthcare providers that Defendants have not entered into PPO or PPN agreements with these providers.

32. As a result of using the silent PPO, Defendants have improperly reduced payments to insureds and medical providers.

33. Defendants' aforesaid utilization of such a program to reduce first-party medical benefits payments is, presumptively, unreasonable.

34. Any expenses not paid or reimbursed under the Defendants' first-party medical coverage by reason of these programs are, *ipso facto*, presumptively owed.

35. Defendants' actions, therefore, in utilizing these programs to unilaterally reduce or deny health care expenses submitted for payment under the Med Pay and/or PIP coverages are, presumptively, in breach of their obligations to pay all reasonable medical expenses incurred by covered persons under the Med Pay and/or PIP provisions of their policies.

36. Defendants' actions in utilizing these programs to unilaterally deny or reduce health care expenses submitted for payment under the Med Pay and/or PIP coverages are, further, a presumptive breach of their implied duty of good faith and fair dealing, including their obligation to conduct a full and fair evaluation of each claim and to not unreasonably deny or withhold benefits.

Class Representatives

37. Plaintiff Horton was an insured under an automobile policy with Defendant USAA CIC which provided Med Pay coverage.

38. Plaintiff Horton paid a premium for the aforesaid Med Pay coverage.

39. On or about December 28, 2004, Plaintiff Horton, as a covered person, was involved in an automobile accident in Phoenix, Arizona.

40. As a direct and proximate result of that automobile accident, Plaintiff Horton sustained certain medical and dental expenses, all reasonably and necessarily incurred.

41. Plaintiff Horton timely notified USAA CIC of the automobile accident and her claim for payment of related, reasonably incurred medical and dental expenses.

42. Plaintiff Horton did not have any applicable dental insurance at the time of said accident and injury.

43. Based on the use of the medical bill audit, Defendant USAA CIC failed and refused to pay for no less than $1,573.67 in related dental expenses. In particular, USAA CIC refused to pay portions of charges for an occlusal orthotic device and comprehensive oral evaluation based on the determination, using the computer software program, that the submitted charges were not "reasonable."

44. As a result of Defendant USAA CIC's refusal to pay the full billed amount, Plaintiff Horton has been required to pay and has paid the balance of the dental expenses reasonably and necessarily incurred.

45. The dental services were covered under Plaintiff Horton's Med Pay coverage in her Policy.

46. Defendants' actions, as aforesaid, have left Plaintiff Horton, and others similarly situated, indebted to health care providers for the difference between the amounts actually incurred and those actually paid or reimbursed by Defendants.

47. Defendants knew and/or consciously disregarded the fact that Plaintiff Horton, and others like her, would be subjected to unnecessary indebtedness and/or causes of action as a result of the actions undertaken by the Defendants as alleged herein.

48. Plaintiff Horton, and others like her, have been damaged as a result of Defendants' automated program for the adjustment of legally-incurred medical expenses.

49. Plaintiff Alstrin was an insured under an automobile policy with Defendant USAA CIC which provided Med Pay coverage.

50. Plaintiff Alstrin paid a premium for the aforesaid Med Pay coverage.

51. On or about January 8, 2007, Plaintiff Alstrin, as a covered person, was involved on an automobile accident in Phoenix, Arizona.

52. As a direct and proximate result of that automobile accident, Plaintiff Alstrin sustained certain medical expenses, all reasonably and necessary.

53. Plaintiff Alstrin timely notified USAA CIC of the automobile accident and his claim for payment of related, reasonably incurred medical expenses.

54. Based on the use of the medical bill audit, Defendant USAA CIC failed and refused to pay for related medical expenses that Alstrin incurred. In particular, USAA CIC refused to portions of charges based on a determination, using the computer software program, that the submitted charges were not "reasonable."

55. As a result of Defendant USAA CIC's refusal to pay the full billed amount, Plaintiff Alstrin has been required to pay and has paid the balance of medical expenses reasonably and necessarily incurred.

56. The medical expenses were covered under Plaintiff Alstrin's Med Pay coverage in his policy.

57. Defendants' actions, as aforesaid, have left Plaintiff Alstrin, and others similarly situated, indebted to health care providers for the difference between the amounts actually incurred and those actually paid or reimbursed by Defendants.

58. Defendants knew and/or consciously disregarded the fact that Plaintiff Alstrin, and others like him, would be subjected to unnecessary indebtedness and/or causes of action as a result of the actions undertaken by the Defendants as alleged herein.

59. Plaintiff Alstrin, and others like him, have been damaged as a result of Defendants' automated program for the adjustment of legally-incurred medical expense.

Class Definition

60. There exists a class of persons, who are Defendants' insureds with Med Pay and/or PIP coverage.

61. This class ("Class") is, or can be initially, defined as follows:

(1) All insureds under auto policies with Med Pay, PIP, First Party Benefit, Medical Expense Benefits, Automobile Death and Disability, or any other first-party medical coverage (collectively referred to

as "Medpay") issued by USAA who were injured in covered automobile accidents,

(a) who made claims for Medpay benefits ("Medpay benefits") from June 27, 2005 through the present, and

(b) who had bills for health care expenses submitted to a medical/fee review audit ("Audit") by AIS, or its parents, subsidiaries or affiliates, which recommended payment of less than the full amount of those submitted bills; and

(c) USAA paid less than the full amount of those submitted health care charges as a result of AIS payment recommendations based on,

i) in whole or in part, a statistical analysis of the reasonableness of the submitted charge,

ii) the application by AIS of a PPO or PPN agreement determined by AIS to be applicable to the submitted charge, or

iii) the resolution of the submitted charge by negotiation between USAA, or AIS on behalf of USAA, and the provider; and

(d) USAA paid an amount less than the limits of coverage for Medpay benefits under the applicable auto insurance policy; and

(2) Health care providers with valid written assignments of any of the claims identified above.

62. Excluded from the Class are officers, directors and employees of USAA, and Class counsel, and their immediate families and persons who have previously resolved all their claims by settlement, release, judgment, or arbitration.

63. This action is brought and may properly be maintained as a class action.

64. The proposed Class is so numerous that the individual joinder of all members is impracticable under the circumstances of this case. While the exact number of class members is unknown to Plaintiffs at this time, Plaintiffs are informed and believe that the proposed Class includes thousands of members throughout the United States.

65. Class treatment is appropriate in this case because (1) it involves the legality of uniform policies and practices that Defendants applied to all members of the proposed Class, and (2) there are numerous common questions of law and fact that exist as to all members of the proposed Class which predominate over any questions that affect only individual members of the proposed Class.

66. Plaintiffs' claims are typical of the claims of the members of the proposed Class. Plaintiffs and all members of the proposed Class sustained injuries arising out of Defendants' common courses of conduct.

67. Plaintiffs will fairly and adequately represent and protect the interests of the proposed Class. Plaintiffs are adequate representatives of the class and have no interest adverse to the proposed Class.

68. All claims on behalf of the proposed Class, including the claims of the Plaintiffs, arise from the same scheme and practice and are based on the same legal theories. The issues that affect Plaintiffs and the proposed Class predominate over those that affect only individual members of the proposed Class.

69. A class action is a superior means for a fair and efficient adjudication of the matters at issue because individual joinder of all members of the proposed Class is impracticable. Additionally, the damages suffered by any individual member of the

proposed Class may be relatively small, making the burden and expense of individual litigation difficult or prohibitive. Moreover, individual adjudication of claims of the members of the proposed Class presents the possibility of inconsistent and contradictory judgments.

70. Plaintiffs anticipate no unusual problems with management of this action as a class action.

COUNT I

Breach of Contract

71. Plaintiffs hereby repeat, reallege, and restate the foregoing as if fully set forth hereby.

72. The policies of insurance between Defendants and Plaintiffs, either directly or through proper assignment, constitute lawfully binding contracts.

73. Plaintiffs have demanded performance under the contracts.

74. Defendants' failures to perform as required under the contracts constitute breaches thereof.

75. Plaintiffs have sustained actual damages as a result of Defendants' breaches.

76. Plaintiffs are entitled to reasonable attorneys' fees under A.R.S. § 12-341.01.

COUNT II

Breach of Covenant of Good Faith and Fair Dealing ("Bad Faith")

77. Plaintiffs hereby repeat, reallege, and restate the foregoing as if fully set forth hereby.

78. Defendants, at all relevant times, owed and continue to owe Plaintiffs an implied duty of good faith and fair dealing.

79. Defendants' actions as aforesaid and as elsewhere set forth herein were in breach of the duty of good faith and fair dealing, and constitute, thereby, "bad faith."

80. Defendants' bad faith conduct consists of, but is not limited to:

a. Failing to fully, fairly and promptly investigate Plaintiffs' claims;

b. Unreasonably denying and/or withholding benefits under the policy;

c. Misconstruing policy language against Plaintiffs;

d. Arbitrarily reducing benefits due and payable under the policy;

e. Creating unreasonable burdens for payment of benefits;

f. Failing to give Plaintiffs' interests equal consideration; and

g. Engaging in a pattern and practice of similar illicit claim practices.

81. Defendants' actions were committed in bad faith against Plaintiffs Horton and Alstrin and the putative Class members.

82. Plaintiffs and the putative Class members have sustained actual damages as a result of Defendants' bad faith conduct.

83. Defendants' actions entitle Plaintiffs and others like them to payment or reimbursement of legally incurred but unpaid medical expenses.

84. Plaintiffs have sustained additional, consequential and general damages, including those for emotional distress and discomfort.

85. Defendants' actions further entitle Plaintiffs and others like them to an award of general damages for Defendants' bad faith conduct.

86. Defendants' actions were undertaken with and evil mind and/or in conscious disregard for the harm to be occasioned by the Plaintiffs.

87. Defendants' actions, for the reasons aforesaid, further entitle Plaintiffs and other like them to an award of punitive damages.

88. Plaintiffs are also entitled to their reasonable attorneys' fees pursuant to A.R.S. § 12-341.01.

WHEREFORE, Plaintiffs demand judgment in their favor and against Defendants as follows:

AS TO THE FIRST COUNT FOR BREACH OF CONTRACT

1. For an order certifying this as a class action, appointing Plaintiffs as class representatives, and appointing Plaintiffs' counsel as class counsel;

2. For a determination that Defendants have breached their contracts with Plaintiffs and the proposed Class;

3. For an award of the actual damages sustained thereby;

4. For Plaintiffs' reasonable attorneys' fees and costs; and

5. For such additional and further relief as the Court deems proper under the circumstances.

AS TO THE SECOND COUNT FOR BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING

1. For an order certifying this as a class action, appointing Plaintiffs as class representatives, and appointing Plaintiffs' counsel as class counsel;

2. For a determination that Defendants have breached the implied covenant of good faith and fair dealing in their policies with the proposed Class;

3. For an award of the actual damages sustained thereby;

4. For an award of general compensatory damages sustained thereby;

5. For an award of punitive damages sustained thereby; and

6. For Plaintiffs' reasonable attorneys' fees and costs incurred pursuant to A.R.S. § 12-341.01.

DATED: June 6, 2008.

SURRANO LAW OFFICES

By: /s/ John N. Wilborn
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Trinette G. Kent
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CERTIFICATE OF SERVICE

I hereby certify that on June 6, 2008, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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s/Kathleen Mohr

CERTIFICATE OF SERVICE

I hereby certify that on June 4th, 2008, I electronically transmitted the foregoing document to the Clerk's Office using the ECF System for filing and mailed a copy to the following ECF registrants:

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