EXHIBIT B

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MONTANA THIRTEENTH JUDICIAL DISTRICT COURT, YELLOWSTONE COUNTY

PETER BYORTH and ANN McKEAN, on behalf of themselves and all those similarly situated, Plaintiffs, vs. USAA CASUALTY INS. CO. and JOHN DOES I-X, Defendants.	Cause No.: DV-15-0511 Judge Gregory R. Todd **FIRST AMENDED COMPLAINT AND JURY DEMAND** ***PUTATIVE CLASS ACTION***

Plaintiffs Peter Byorth and Ann McKean, on their own behalf and on behalf of all Montanans similarly situated, through their undersigned attorneys, hereby

complain and allege for their First Amended Complaint against Defendant USAA Casualty Ins. Co. as follows:

SUMMARY OF CASE

1. This is a class action lawsuit on behalf of Plaintiffs and all similarly situated Montanans against Defendant USAA Casualty Ins. Co. ("USAA") for its implementation of an improper scheme designed to wrongfully deny Montana consumers their first-party medical payment insurance benefits. This action seeks to remedy USAA's illegal conduct and enjoin it from continuing to perpetrate this scheme against Montana insurance consumers.

PARTIES AND JURISDICTION

2. Plaintiff Peter Byorth ("Byorth") was, at all times relevant hereto, a resident of Yellowstone County, Montana. Byorth paid insurance premiums to USAA in exchange for first-party medical payments insurance.

3. Plaintiff Ann McKean ("McKean") was, at all times relevant hereto, a resident of Yellowstone County, Montana. McKean paid insurance premiums to USAA in exchange for first-party medical payments insurance.

4. At all times material hereto, Defendant USAA was a foreign insurer engaged in the insurance business in the State of Montana. USAA accepted insurance premium payments from Byorth and McKean in exchange for providing them with first-party medical payments insurance.

5. This Court has jurisdiction over the parties and the subject matter of this lawsuit.

6. Venue is correct in Yellowstone County, Montana.

ALLEGATIONS COMMON TO ALL COUNTS

7. USAA specifically targets and markets to Montana service members and their families for the purpose of selling insurance products. USAA represents to these servicemen and servicewomen and their families that it is committed to taking care of and supporting them and their families, and touts that "[w]hen you join USAA, you become part of a family that's there for you every stage of your life."

8. USAA offered and sold in Montana a form of first-party medical payments insurance that pays an insured's medical expenses, regardless of fault, in the event of an accident or occurrence. This type of insurance is commonly referred to in Montana as "Med Pay" coverage.

9. Plaintiffs, and other similarly situated Montanans, purchased Med Pay coverage from USAA. Plaintiffs submitted claims to USAA under their Med Pay coverages that were improperly handled and denied.

10. Under the terms of USAA's Med Pay insurance policies in Montana, USAA assumed the responsibility and obligation to conduct a reasonable investigation and make coverage decisions based upon all available information,

and to pay all medical expenses incurred for the treatment of injuries sustained in a covered accident or occurrence.

11. Despite that obligation, USAA has adopted an undisclosed and illegal scheme through which USAA arbitrarily denies and/or reduces Med Pay claims submitted by its insureds. USAA's scheme operates to uniformly deny and reduce medical claims submitted by insureds relating to a covered accident or occurrence for which insureds seek medical care. Through its scheme, USAA essentially engages in a war of attrition, making it so difficult and time consuming for insureds to obtain their rightful benefits that insureds eventually just give up. The result of the scheme is that USAA wrongfully keeps significant sums of money that rightfully belong to its insureds in Montana.

12. To implement and carry out USAA's unlawful scheme, USAA entered into a Master Services Agreement ("MSA") with a third-party known as Auto Injury Solutions, Inc. ("AIS") under the guise of AIS providing "independent" and impartial medical bill audit services for the purposes of limiting insurance fraud.

13. USAA pays AIS to implement the scheme in a manner that uniformly and arbitrarily denies and/or reduces medical payment claims from insureds, and denies claims without conducting a reasonable investigation based on all available information. AIS's process is an automated, computer based system which relies

on technology to reject as many claims as possible without requiring any human investigative input or review, as required by Montana law, of actual medical records.

14. Upon information and belief, USAA's payment structure incentivizes AIS to uniformly and arbitrarily reduce medical payment reimbursements to insured's and their health care providers by paying AIS a percentage of the savings resulting from the unlawful scheme.

15. AIS serves as USAA's agent in connection with USSA's handling of Med Pay claims submitted by its insureds from Montana.

16. Pursuant to the MSA, USAA delegates its responsibility and obligation to properly adjust claims and to determine whether medical expenses are reasonable to AIS.

17. When an insured submits a claim to USAA, they and their health providers are instructed to send the insured's claim information (medical bills and records), including any appeals, to AIS, not to USAA.

18. Upon receipt of receipt claim information from an insured, AIS conducts what is referred to by USAA as a Medical Bill Audit ("MBA") process. The MBA process is designed, largely through automated computer processes, to categorically eliminate, abate, and/or reduce the amount USAA pays for its insured's health care expenses based upon coding errors, sham medical necessity

reviews, and confidential statistical information, rather than the individual character of health care services required by an insured and their related expenses.

19. For example, the MBA process automatically denies an insured's claim if the related medical bill contains a coding error, even though a quick review of the associated medical records informs USAA and AIS that the bill should be paid despite the coding error.

20. Further, the purported medical review services provided by AIS as part of the MBA are a sham. The records review reports ("Reports") generated by AIS purportedly created by physicians and nurses with whom AIS contracts to provide "independent" medical record review services uniformly deny reimbursement for treatment received by USAA's insureds on the basis that the treatment was unnecessary. These Reports are prepared without basis in fact, are not supported by proper sources, and are contrary to the health treatment plan implemented by the insured's treating health care providers.

21. Also, AIS utilizes a computer software program to determine the amount USAA will pay for health care charges submitted by its insureds. AIS's computer software program uniformly, unilaterally, and arbitrarily makes two types of reductions.

a. First, AIS's software uniformly, unilaterally, and arbitrarily reduces the amount USAA will reimburse on health care

providers' bills based upon a determination that the amounts billed were not "reasonable." AIS's software uniformly, unilaterally, and arbitrarily reduces the amount paid to an insured's health care provider based upon unidentified, confidential data linking like charges for services of other similar health care providers in an insured's geographic area. USAA then pays an arbitrarily generated allowed amount for charges in a given geographical region under the guise that the lower amount is "reasonable."

b. Second, AIS has secured access to databases containing information relating to allowable billing rates under agreements with preferred provider organizations (PPOs) and preferred provider network (PPNs). USAA, who has no direct PPO or PPN agreements with insureds' health care providers, wrongfully utilizes AIS's PPO and PPN databases to reduce the amounts USAA will reimburse their insureds or pay on behalf of their insureds under their Med Pay coverage.

22. A result of USAA's MBA process is that its insureds are frequently balanced billed by their health care providers.

23. The MBA authorizes AIS to submit a claim denial on behalf of USAA to the insured without actually reviewing the associated medical records and without any input from USAA.

24. In sum, USAA's claim processing system, ran through AIS, is designed to reject claims at every possible level without a reasonable investigation based upon all available information. Such a process is contrary to Montana law.

ALLEGATIONS REGARDING CLASS REPRESENTATIVES

25. Plaintiff Peter Byorth had Med Pay coverage with USAA at all times material hereto.

26. On September 25, 2011, Byorth was seriously injured when he was struck by a motor vehicle while riding his bicycle. At the time of his injury, Byorth had $10,000 in first-party Med Pay coverage through USAA. Byorth incurred over $85,000 in medical bills. Byorth timely submitted proof of loss, proof of treatment, and copies of his medical bills to USAA in connection with the accident.

27. Pursuant to the MSA, USAA referred Byorth's claims to AIS to undergo the MBA process without disclosing to Byorth that USAA delegated its duties to AIS. Byorth's Med Pay claims were improperly delayed, denied and/or reduced during the MBA process. For example, USAA claimed that Byorth's spinal fusion surgery was not medically necessary in spite of the clear medical

evidence and the unequivocal position of Byorth's treating physicians. Further, USAA repeatedly denied Byorth Med Pay benefits on the basis of "coding errors" even though the medical records associated with the medical bills clearly showed the bills were related to the subject accident.

28. USAA caused Byorth damages by wrongfully handling his Med Pay coverage claim including, but not limited to, delaying timely payment of benefits, delaying recovery of his medical treatment, forcing him to retain counsel to get the claim paid and incur legal fees.

29. Plaintiff Ann McKean had Med Pay coverage with USAA at all times material hereto.

30. On February 10, 2014, McKean was seriously injured in a motor vehicle accident. At the time of her injury, McKean had $30,000 in Med Pay coverage through USAA. McKean incurred over $11,600 in medical bills in the first year following the crash as a consequence of her injury. McKean timely submitted proof of loss, proof of treatment, and copies of her medical bills related to the accident.

31. Pursuant to the MSA, USAA referred McKean's claims to AIS to undergo the MBA process without disclosing to McKean that USAA delegated its duties to AIS. McKean's Med Pay claims were improperly denied and/or reduced during the MBA process. For example, USAA claimed that McKean's treatment

was not medically necessary in spite of the clear medical evidence and the unequivocal position of McKean's treating physician. Further, USAA repeatedly reduced the reimbursement amount for McKean's Med Pay benefits on the basis that her medical expenses were not reasonable and/or exceeded PPO and PPN reimbursement rates, even though USAA was not party to any PPO or PPN agreements with McKean's health care providers.

32. USAA caused Ms. McKean damages by wrongfully handling her Med Pay coverage claim including, but not limited to, wrongfully delaying and denying timely payment of benefits, delaying recovery of her medical treatment, and forcing her to retain counsel to get the claim paid.

COUNT I – BREACH OF FIDUCIARY DUTY

33. Plaintiffs incorporate by reference all prior allegations.

34. Defendant owed Plaintiffs and the Class fiduciary duties.

35. Defendant breached its fiduciary duties by utilizing a system designed to reject claims without a reasonable investigation based upon all available information.

36. USAA's use of its illegal scheme resulted in wrongfully delaying and/or denying Plaintiffs and the Class their Med Pay benefits under their insurance policies.

37. As a result of Defendants' breaches, Plaintiffs and the Class have been injured and are entitled to damages.

COUNT II – BREACH OF CONTRACT

38. Plaintiffs incorporate by reference all prior allegations.

39. Plaintiffs and the Class on one hand and USAA on the other hand entered written insurance contracts.

40. Pursuant to the contracts, in exchange for premium payments, USAA implied and covenanted that it would act in good faith and follow the law and the contracts with respect to the prompt and fair payment of first-party Med Pay benefits.

41. USAA breached the contracts by utilizing a system designed to reject claims without a reasonable investigation based upon all available information, and thus, wrongfully delaying and/or denying Med Pay claims, causing Plaintiffs and the Class damages.

COUNT III – UNFAIR TRADE PRACTICES

42. Plaintiffs incorporate by reference all prior allegations.

43. At all times relevant to this Complaint, USAA had the duty to understand and apply the terms of its insurance policies in accordance with, and as required by, well-established principles applicable to the insurance industry.

Specifically, USAA knew it must pay Med Pay benefits to its insureds in accordance with the plain language and requirements of its insurance policies.

44. USAA also had the duty to handle its insureds' claims arising under its Med Pay policies in accordance with standards applicable to the insurance industry and made mandatory by Montana's Unfair Trade Practices Act, Section 33-18-201, M.C.A., pursuant to which it is unlawful and a prohibited practice to: (1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue; (2) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; (4) refuse to pay claims without conducting a reasonable investigation based upon all available information; (6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; (7) compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds.

45. USAA has violated subparagraphs (1), (2), (4), (6) and (7) of the Montana Unfair Trade Practices Act, Section 33-18-201, M.C.A. ("MUTPA") by engaging in a pattern and practice of wrongfully denying Med Pay claims, thus causing Plaintiffs and the Class to suffer injury, harm and loss, giving rise to a general tort action in favor of Plaintiffs pursuant to Section 33-18-242, M.C.A.

COUNT IV – PUNITIVE DAMAGES

46. Plaintiffs incorporate by reference all prior allegations.

47. USAA's conduct towards Plaintiffs and the Class constitutes fraud and/or malice as defined by Montana law for purposes of the imposition of punitive damages.

CLASS ALLEGATIONS

48. Plaintiffs incorporate by reference all prior allegations.

49. Plaintiffs bring this action on their own behalf and on behalf of a class of persons similarly situated pursuant to Rule 23, Montana Rules of Civil Procedure.

50. The class is comprised of all persons who satisfy the following criteria: (a) all Montana consumers who (b) were insured by USAA for Med Pay benefits and (c) who submitted a claim for Med Pay benefits within the applicable statute of limitations, and (d) had their claim processed by AIS, resulting in any rejection or reduction or delay.

51. The class is so numerous that joinder of all members is impracticable. The Complaint concerns a routine insurance claims practice as set forth above. There are common questions of law or fact common to the class. These include whether or not USAA violated Montana law with respect to its Med Pay claims

handling practices. The claims of Plaintiffs are typical of those of the class. All of Plaintiffs' claims are based upon the same factual and legal theories.

52. Plaintiffs will fairly and adequately protect the interests of the class. Plaintiffs have no interest antagonistic to those of the class. Plaintiffs' counsel is competent and experienced in consumer class actions and insurance litigation.

53. USAA has acted on grounds generally applicable to the class, thereby making final relief and declaratory relief appropriate with respect to the class as a whole.

54. The questions of law and fact common to the class predominate over any question affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy. The class members are consumers who may be unable to locate or afford attorneys. Most are probably unaware that their rights under Montana law have been violated. The amounts of actual damages per consumer, while not insignificant to a consumer, are generally small, and thus a consumer class action is particularly well-suited to address violations and for recovery by the class.

55. The class may be certified under Rule 23(b)(3), Mont. R. Civ. P., as such represents a superior method for the fair and efficient adjudication of this controversy in that:

(a) Most of the class members are not aware of their rights and have no knowledge that their rights have been violated.

(b) The interest of class members individually controlling the prosecution of separate claims is small because of the limited damages per consumer.

(c) Management of this class action is not likely to present significant difficulties.

(d) Defendant acted on grounds generally applicable to the class thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

(e) Certification of a class under Rule 23 of the Montana Rules of Civil Procedure is appropriate in that Defendants have acted on grounds generally applicable to the class thereby making appropriate declaratory relief with respect to the class as a whole.

56. Plaintiffs request certification of a class action.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs, on behalf of themselves and the putative class, respectfully requests the following relief against Defendant:

a. This Court certify the class and appoint Plaintiffs class representative and their attorneys as class counsel.

b. Actual damages, statutory damages, exemplary/punitive damages, costs and attorney's fees.

c. For an order of disgorgement and/or restitution.

d. For pre-judgment interest to the extent permitted by law.

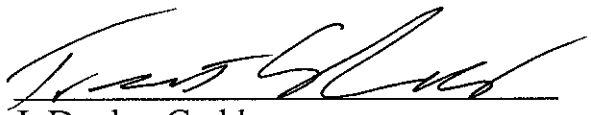
e. Such other and further relief as the Court may deem just and proper.

JURY DEMAND

Plaintiffs demands a trial by jury on all claims.

Dated this 20th day of October, 2017.

GOETZ, BALDWIN & GEDDES, P.C.



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that the foregoing document was served upon the following, by the means designated below, this 20th day of October, 2017.

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