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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

CHRISTIANE CALLIL, Plaintiff and Appellant, v. CALIFORNIA PHYSICIANS' SERVICE, Defendant and Respondent.	B203085 (Los Angeles County Super. Ct. No. BC355338)

APPEAL from a judgment of the Superior Court for Los Angeles County, Ann I. Jones, Judge. Reversed.

Shernoff Bidart Darras Echeverria, William M. Shernoff, Evangeline F. Grossman, and Joel A. Cohen; the Ehrlich Law Firm and Jeffrey Isaac Ehrlich for Plaintiff and Appellant.

Manatt, Phelps & Phillips, Brad Seiling, Joanna S. McCallum, John T. Fogarty and Gregory N. Pimstone for Defendant and Respondent.

The question presented in this case is whether a health care service plan "complete[s] medical underwriting" under Health and Safety Code section 1389.3 (section 1389.3) if, before issuing a plan contract, it does not attempt to check the accuracy of an application that itself does not raise any questions regarding the applicant's medical condition.[1] In *Hailey v. California Physicians' Service* (2007) 158 Cal.App.4th 452 (*Hailey*), the Fourth District, Division Three examined a health care service plan's duty under section 1389.3, and concluded that the plan must make "reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process." (*Id.* at p. 459.) We agree with the *Hailey* court's thoughtful and careful analysis. Accordingly, we reverse the summary judgment in this case.

BACKGROUND

This case involves the rescission of a health plan contract. In January 2005, plaintiff Christiane Callil submitted an application for an individual health plan with defendant California Physicians' Service dba Blue Shield of California (Blue Shield). Callil had been covered under a Blue Shield individual plan in the past (from August 2001 until September 2003), and was covered under a Blue Shield group HMO plan at the time she submitted her January 2005 application.[2]

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[1] Section 1389.3 provides: "No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, 'postclaims underwriting' means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation."

[2] Callil had applied for an individual plan previously, in January 2004. The application was not approved because Blue Shield determined that Callil had omitted information from her application.

Because she was already covered under a Blue Shield plan, Callil checked the box on the application stating that she was applying for a plan transfer. In fact, Blue Shield does not consider a change from a group plan to an individual plan to be a transfer because, unlike an individual plan, a group plan does not involve individual underwriting. Therefore, Blue Shield requires an applicant for an individual plan to submit an application disclosing his or her medical conditions, even if the applicant is already covered under a Blue Shield group plan.

The application for a Blue Shield individual plan requires the applicant to answer a series of questions regarding his or her medical history. For example, it asks whether the applicant has, in the last 20 years, received any professional advice or treatment from a licensed health practitioner, or had any symptoms pertaining to various conditions (such as skin conditions), diseases (such as cancer), or systems (such as the "female reproductive system"). In most categories, the application lists examples of conditions, diseases, or symptoms. For example, under "female reproductive system" the application lists several potential issues, such as fibroid tumors and abnormal bleeding. The application also asks whether the applicant has been advised to have further testing, treatment, or surgery that has not yet been performed, or has been prescribed any medication within the past 12 months. Finally, the application asks for the date of the applicant's last doctor's visit, the name of the physician, the reason for the visit, findings from the visit, and present status, and requires the applicant to sign an authorization to allow any healthcare provider to disclose to Blue Shield all medical information regarding the applicant.

On the application Callil submitted in January 2005, she had answered "No" to every question regarding treatment or symptoms (other than the question asking

whether the applicant menstruates). She also answered "No" to the questions regarding whether she had been advised to have further testing, treatment, or surgery, or had been prescribed any medication in the previous 12 months. When she first submitted her application, she failed to provide the information regarding her last doctor's visit, and Blue Shield asked her to provide that information. She then indicated that her last visit was a physical on December 3, 2002, with Dr. Robert Katz, that there were no findings, and that her present status was "great."

Upon receiving Callil's application, Blue Shield reviewed its claims system (since Callil was covered under a Blue Shield group plan and had been covered under an individual plan in the past), and asked Callil to provide information about ambulance services she had received in May 2004. Callil responded, "That evening I had pain cramps so I call 911 once I got to the hospital I felt better so I never got treated I just went home -- I'm fine now." Based upon the information Callil provided in her application and in response to Blue Shield's requests for information, Blue Shield approved her for coverage effective April 1, 2005. Despite Callil's signed authorization, Blue Shield did not request any medical information from Callil's physician before it approved her application.

Sometime after Callil was approved, Dr. Katz sought pre-authorization for surgical services, specifically, a hysterectomy. On August 31, 2005, Blue Shield's Care Management Department issued a conditional pre-authorization for the surgery. That same day, Blue Shield's Medical Management Department referred the case to the Underwriting Investigative Unit (UIU), as is Blue Shield's policy whenever a provider makes a request for pre-authorization for services within two years after the effective date of coverage. Paula Wells, of the UIU, was assigned to investigate the matter.

Wells reviewed Callil's application, the additional information she provided in response to Blue Shield's requests, and various records regarding Callil

available on Blue Shield's computer system (e.g., the subscriber summary of claims) to determine if the original underwriter who approved Callil's application properly handled the matter. Wells concluded the underwriter acted properly based upon the information Callil provided, and further concluded that "there were no claims in the Blue Shield system that would have raised a question or caused the underwriter to order medical records or conduct any further investigation or inquiry."[3]

Wells then requested medical records from various providers who had provided medical care to Callil from January 2003 through September 2005. Upon obtaining those records, Wells discovered that Callil had a history of uterine fibroids and heavy and irregular menstrual bleeding. The records from Women's Care of Beverly Hills (Dr. Katz's office) showed that Callil had an ultrasound taken in March 2003 that revealed multiple fibroids. She had another ultrasound taken in May 2004 that showed the fibroids had increased. In August 2004, Callil complained of very heavy menses, and Dr. Katz discussed possible options with her, including surgery. In December 2004 (a few weeks before she submitted her application to Blue Shield), Callil had "multiple telephone conversations" with Dr. Katz regarding dysmenorrhea (painful menstruation) and menorrhagia (heavy bleeding). Dr. Katz discussed her options, including myomectomy (surgical removal of the fibroids) and hysterectomy (removal of the uterus). In addition to

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[3] We note that the computer printouts Wells attached to her declaration appear to disclose several claims made for services to Callil in 2003 and 2004. Because there is no explanation for the abbreviations and codes used on these printouts, we do not know what kinds of services were provided, or who was the provider of the services. We also note that Blue Shield also had in its files the application Callil submitted in January 2004, on which she stated that her last doctor's visit was with Dr. Mazouz in November 2003. This statement is inconsistent with her statement in her January 2005 application that her last doctor's visit was with Dr. Katz in December 2002.

the records from Women's Care of Beverly Hills, Wells obtained records from Cedars-Sinai Medical Center and Olympic Blvd. Pharmacy. Those records showed that Callil had surgery in 1999 to remove uterine fibroids and that she had numerous prescriptions filled in 2003 and 2004.

Wells determined that, based upon Blue Shield's underwriting guidelines, Blue Shield would not have extended coverage to Callil had she disclosed her actual medical history. The day after Blue Shield received Callil's medical records from Women's Care of Beverly Hills, it sent Callil a letter informing her that Blue Shield had rescinded her health plan contract. In the meantime, Callil had a hysterectomy based upon Blue Shield's conditional pre-authorization, and was hospitalized for three days following surgery; she was discharged from the hospital five days before the rescission letter was sent. She incurred more than $50,000 in hospital bills.

Callil appealed Blue Shield's rescission decision to Blue Shield's Appeals and Grievance Department. After Blue Shield denied her appeal, she filed the instant lawsuit alleging claims for breach of contract, breach of the duty of good faith and fair dealing (the bad faith claim), and declaratory relief.[4]

Blue Shield moved for summary judgment/summary adjudication on the ground that it was entitled to rescind the health plan contract due to Callil's material omissions and/or misrepresentations on her application. Relying upon

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[4] Callil's original complaint also alleged a claim under Business and Professions Code section 17200 et seq., but Callil voluntarily dismissed that claim.

case law involving insurance policies,[5] Blue Shield argued that, because Callil's omissions or misrepresentations were material (i.e., Blue Shield would not have issued the contract if Callil's answers had been truthful), Callil's intent was irrelevant. Blue Shield also argued that section 1389.3 did not apply because there were no "reasonable questions" raised by Callil's application that required resolution before issuance of the plan contract, and therefore Blue Shield did not engage in postclaims underwriting as defined by section 1389.3. In support of its motion, Blue Shield submitted, among other evidence, Callil's deposition testimony in which she admitted knowledge of her fibroids and her doctor's recommendation of surgery, and the declaration of Paula Wells, who stated that Blue Shield would have denied Callil's application if Callil had disclosed the information regarding her fibroids.

In opposition to the summary judgment motion, Callil argued that Blue Shield's reliance on insurance policy cases was misplaced because its right to rescind a health plan contract is governed not by the Insurance Code, but rather by the Health and Safety Code. Callil argued that, unlike in the insurance context, where an insurance company may rescind a policy if the insured made any material omission or misrepresentation in his or her application, a health care service plan's right to rescind is limited by section 1389.3, which permits rescission only upon a showing of willful misrepresentation. Callil submitted her declaration, in which she stated that she omitted information about her fibroids because she believed they "were a common, minor indisposition experienced by nearly all women." She

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[5] Blue Shield acknowledged that "a 'health care service plan is not necessarily equivalent to an insurance policy for all purposes,'" but noted that "courts 'look to the law on interpretation of insurance contracts' when determining issues relative to the interpretation of health care service plans." (Quoting *Kavruck v. Blue Cross of California* (2003) 108 Cal.App.4th 773, 780, fn. 3.)

declared that she "did not believe that the fibroids detracted from [her] general good health and did not appreciate that they would be significant to obtaining coverage with Blue Shield." Finally, she stated: "I did not willfully misrepresent my health status to Blue Shield, nor did I intend to mislead Blue Shield. I did the best I could with the application with my understanding of what needed to be put on the application. I put down my treating doctor's name and gave Blue Shield permission to get his records should they need to get any medical details about my health status."

In reply to Callil's opposition, Blue Shield reiterated its assertion that Blue Shield was entitled to rescind the plan contract, regardless of Callil's intent, based upon the undisputed facts that (1) Callil knew she had fibroids and that her doctor recommended surgery; (2) the application required that Callil disclose those facts; and (3) Blue Shield would not have extended coverage had Callil disclosed those facts. In any event, Blue Shield argued, Callil could not raise a triable issue of fact by submitting a declaration that it contended contradicted her deposition testimony.

The trial court granted Blue Shield's motion for summary judgment. The court found "it is undisputed that Plaintiff omitted material medical information in her application for coverage. Had Plaintiff fully disclosed her medical condition, she would have been denied coverage." It held that section 1389.3 did not apply in this case because Callil did not disclose any medical conditions on her application, and "[w]here there is no disclosure that would put a reasonable health plan or insurer on notice of the need to conduct further investigation, the prohibition on postclaims underwriting set forth in Section 1389.3 is not triggered." Therefore, although the court acknowledged that Callil "arguably creates a question of fact by her deposition testimony denying any willful intent," it rejected her assertion that Blue Shield could not rescind the plan contract without showing her omission constituted a willful misrepresentation as required under section 1389.3. Rather,

the court concluded that "the traditional legal standards for rescission must be applied," which allow a health plan to rescind "where the applicant made representations or omissions, even if innocent, that were false in a material way on items that were queried in the application."

Callil timely filed a notice of appeal from the judgment.

DISCUSSION

A. *The* Hailey *Decision*

A few months after the notice of appeal was filed, the Fourth District, Division Three issued its decision in *Hailey*, *supra*, 158 Cal.App.4th 452. In that case, Cindy Hailey sought coverage under a Blue Shield family plan for herself, her husband Steve, and their son. Her insurance agent sent her an application, which she completed and sent back to the agent. She mistakenly believed the application requested information related only to her own health, so she did not disclose any health information regarding her husband or son. Based upon the information provided in the application, Blue Shield extended coverage to Cindy and her family. (*Id.* at pp. 460-461.)

A few months later, Steve was admitted to the hospital for stomach problems, and Blue Shield started an investigation to determine if there was fraud in Cindy's application. The following month, Steve was in an automobile accident that left him completely disabled. He was hospitalized for more than two months, and was released with instructions for additional home nursing care and physical therapy. The day after his discharge from the hospital, Blue Shield notified the Haileys that their health plan contract had been rescinded based upon Steve's medical records (which Blue Shield had obtained during its investigation), which showed that Steve had a history of health issues that were not disclosed in the application for coverage. Blue Shield demanded that the Haileys pay it more than

$60,000, i.e., the difference between the amount Blue Shield had paid on claims for Steve's medical care and the premiums the Haileys had paid to Blue Shield. As a result of the rescission of their health plan contract, the Haileys could not afford the nursing care or physical therapy Steve required, and were presented with demands for payment from third party medical providers for services already rendered (the total amount exceeded $457,000). (*Hailey*, *supra*, 158 Cal.App.4th at p. 461.)

The Haileys sued Blue Shield for breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress. The trial court granted Blue Shield's motion for summary judgment, finding that the Haileys' omissions and misrepresentations on their application justified rescission. (*Hailey*, *supra*, 158 Cal.App.4th at p. 462.) The Haileys appealed, arguing that section 1389.3 precluded Blue Shield from rescinding the contract unless it could prove that the Haileys willfully misrepresented Steve's health when they applied for coverage. The appellate court reversed the summary judgment, concluding that "section 1389.3 precludes a health services plan from rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate (1) the misrepresentation or omission was willful, or (2) it had made reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process." (*Id.* at p. 459.)

In reaching this conclusion, the *Hailey* court first examined the purpose of the Knox-Keene Health Care Service Plan Act (Health & Saf. Code, § 1340 et seq.) and the purpose of section 1389.3 in particular. The court noted that the purpose of the Act is to transfer the financial risk of health care from patients to providers and health service plans, while the purpose of section 1389.3 is to prevent plans from shifting the financial risk of health care back to the patients. (*Hailey*, *supra*, 158 Cal.App.4th at p. 463.)

Next, the court examined postclaims underwriting -- the conduct section 1389.3 seeks to eliminate -- and the harm that results from it. It explained that "postclaims underwriting occurs when an insurer '"wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued."'" (*Hailey, supra*, 158 Cal.App.4th at p. 465.) The court found the harm from this practice is manifest: "'An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed. It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is *not* insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs. . . . If the insured is not an acceptable risk, the application should [be] denied up front. . . . This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury.'" (*Ibid.*)

Finally, the court examined the language of section 1389.3. The statute defines "postclaims underwriting" as "the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract." (§ 1389.3.) The court focused on the phrase "complete medical underwriting." Blue Shield argued it completes medical underwriting by resolving any questions that arise from the answers given by the applicant on the application. But the court asked, "[C]an a provider 'complete medical underwriting' within the meaning of section 1389.3 by blindly accepting the responses on a subscriber's application without performing any inquiry into whether the responses were the result of mistake or inadvertence?"

(*Hailey*, *supra*, 158 Cal.App.4th at p. 466.) The court reasoned that, in order to effectuate the purpose of section 1389.3 -- i.e., "to prevent the unexpected cancellation of health care coverage at a time coverage is needed most" (*id.* at p. 467) -- the phrase "complete medical underwriting" must be interpreted to "require a plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete" before issuing the plan contract. (*Id.* at p. 469.)

Summing up, the court clarified the duties and rights of applicants and health services plans under section 1389.3: "An applicant for a health services plan has a responsibility to exercise care in completing an application. In light of the potentially catastrophic consequences of an applicant's error in filling out an application, however, we believe the Legislature has placed a concurrent duty on the plan to make reasonable efforts to ensure it has all the necessary information to accurately assess the risk before issuing the contract, if the plan wishes to preserve the right to later rescind where it cannot show willful misrepresentation." (*Hailey*, *supra*, 158 Cal.App.4th at p. 471.) The court reversed the summary judgment in favor of Blue Shield because Blue Shield failed to show it made reasonable efforts to ensure the accuracy and completeness of the Haileys' application, and there was a triable issue of fact regarding whether Cindy willfully misrepresented Steve's medical condition when they submitted the application. (*Id.* at p. 472.)

B. *Breach of Contract Claim*

On appeal in this case, Callil urges us to follow the reasoning of *Hailey*, and reverse the summary judgment on the ground that there is a disputed issue of fact regarding whether Callil willfully misrepresented or omitted facts about her medical health. Blue Shield argues that *Hailey* was wrongly decided, but that in any event, summary judgment was proper because the evidence establishes that

Callil's misrepresentations were willful and that Blue Shield took reasonable steps to confirm the accuracy of Callil's application. We disagree.

The *Hailey* decision provides a careful, thoughtful, and thorough analysis of section 1389.3 and the conduct it was designed to proscribe. We agree with its reasoning and its conclusion: section 1389.3 precludes a health care services plan from rescinding a health plan contract based upon an applicant's misrepresentation or omission unless it can demonstrate *either* that the misrepresentation or omission was willful *or* that it made reasonable efforts to ensure the accuracy and completeness of the application before issuing the contract. (*Hailey, supra*, 158 Cal.App.4th at p. 459.) In this case, the record discloses triable issues of fact regarding whether Callil's misrepresentations or omissions were willful, and whether Blue Shield "complete[d] medical underwriting" under section 1389.3, as interpreted in *Hailey*.

To be sure, Blue Shield presented evidence -- Callil's admissions that she was aware of her fibroid condition and repeatedly sought medical care related to that condition -- from which a trier of fact reasonably could infer that Callil's misrepresentations or omissions were willful. But Callil presented evidence -- her declaration and deposition testimony -- that she did not believe that her fibroids were significant and did not willfully withhold information about them. As the trial court noted, although Callil's "failures to disclose were sufficiently profound and complete that the Court might be able to reasonably infer that they were made willfully, . . . [Callil] arguably creates a question of fact by her [declaration and] deposition testimony denying any willful intent." (See *Binder v. Aetna Life Ins. Co.* (1999) 75 Cal.App.4th 832, 840 ["the trial court [may not] grant summary judgment for a defendant based simply on its opinion that plaintiff's claims are 'implausible,' if a reasonable factfinder could find for plaintiff on the evidence presented"].)

There also is a triable issue regarding whether Blue Shield satisfied its duty to take reasonable steps to confirm the accuracy and completeness of Callil's application. Although Blue Shield presented evidence that it took steps to ensure the completeness of Callil's application -- for example, it asked her to provide information regarding her last doctor's visit, which Callil had omitted on her original application -- it presented no evidence to show that it took reasonable steps to confirm the accuracy of the application, even based on information already in its possession. For example, according to the evidence Blue Shield presented, Blue Shield had a document in its files that indicated Callil's response to the request for information about her last doctor's visit was incorrect -- although Callil stated in response to Blue Shield's request for information that the visit was with Dr. Katz in December 2002, her January 2004 application stated that her last visit was with Dr. Mazouz in November 2003[6] -- yet Blue Shield conducted no follow up to determine which answer was correct.

Based upon the evidence presented, a trier of fact reasonably could conclude that Blue Shield failed to satisfy its duty to "complete medical underwriting," and therefore could not rescind the plan contract unless Callil's misrepresentations or omissions were willful. Because there is a triable issue on the question of willfulness, the summary judgment in favor of Blue Shield must be reversed.

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[6] We note that in her declaration, Marjorie Drake (who works for Blue Shield as a "Consultant/Lead for projects affecting IFP underwriting") states that Callil stated on her January 2004 application that her visit with Dr. Mazouz was in November 2002. But the application actually shows that the visit was in November 2003, which is confirmed in Callil's deposition testimony.

C. *Bad Faith and Punitive Damages Claims*

Blue Shield contends that, even if there is a disputed issue that precludes summary judgment, it nevertheless is entitled to summary adjudication of Callil's bad faith and punitive damages claims. We disagree.

"'The implied [covenant of good faith and fair dealing] requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's benefits. To fulfill its implied obligation, an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests.'"[7] (*Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720 (*Wilson*).) For example, an insurer may not deny a claim without fully investigating the grounds for its denial. (*Ibid.*) "To protect its insured's contractual interest in security and peace of mind, 'it is essential that an insurer fully inquire into possible bases that might support the insured's claim' before denying it." (*Id.* at p. 721.)

Callil alleged that Blue Shield breached the implied covenant of good faith and fair dealing by, among other things, engaging in postclaims underwriting in violation of section 1389.3, rescinding her health plan contract, and refusing to pay benefits owed under the contract. Blue Shield argues Callil cannot recover under this claim, however, because the undisputed facts demonstrate there was a genuine dispute over coverage that precludes liability.

Blue Shield is correct that "'an insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not

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[7] "Although health care plans are governed by a different set of statutes and regulations than insurers, both are equally bound by the duty of good faith and fair dealing." (*Hailey, supra,* 158 Cal.App.4th at p. 472.)

liable in bad faith even though it might be liable for breach of contract.'" (*Wilson*, *supra*, 42 Cal.4th at p. 723.) But "[t]he genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A *genuine* dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds. [Citations.] Nor does the rule alter the standards for deciding and reviewing motions for summary judgment. 'The genuine issue rule in the context of bad faith claims allows a [trial] court to grant summary judgment when it is undisputed or indisputable that the basis for the insurer's denial of benefits was reasonable—for example, where even under the plaintiff's version of the facts there is a genuine issue as to the insurer's liability under California law. [Citation.] . . . On the other hand, an insurer is not entitled to judgment as a matter of law where, viewing the facts in the light most favorable to the plaintiff, a jury could conclude that the insurer acted unreasonably.' [Citation.] Thus, an insurer is entitled to summary judgment based on a genuine dispute over coverage or the value of the insured's claim only where the summary judgment record demonstrates the absence of triable issues [citation] as to whether the disputed position upon which the insurer denied the claim was reached reasonably and in good faith." (*Id.* at pp. 723-724, fn. omitted.)

In the present case, the evidence suggests that Blue Shield issued the plan contract without "complet[ing] medical underwriting" and rescinded the contract without investigating whether Callil's failure to disclose her medical condition was willful. Although a trier of fact could conclude that Blue Shield "'fully inquire[d] into possible bases that might support'" coverage for Callil (*Wilson*, *supra*, 42 Cal.4th at p. 721) and reasonably and in good faith determined that it was entitled to rescind, the trier of fact also could conclude that Blue Shield failed to do so, and therefore find Blue Shield liable for bad faith. Because we must resolve doubts as to whether summary adjudication should be granted in favor of the party opposing

the motion (*Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1071; *Michael J. v. Los Angeles County Dept. of Adoptions* (1988) 201 Cal.App.3d 859, 866), we hold that Blue Shield is not entitled to summary adjudication of Callil's bad faith claim.

Similarly, we find that Blue Shield is not entitled to summary adjudication of the claim for punitive damages. If Callil can prove by clear and convincing evidence that Blue Shield not only rescinded her health plan contract unreasonably or in bad faith, but in doing so was guilty of malice, oppression or fraud, she may recover punitive damages. (*Jordan v. Allstate Ins. Co.*, *supra*, 148 Cal.App.4th at p. 1080.) As noted above, a reasonable trier of fact could determine that Blue Shield engaged in bad faith by rescinding the plan contract. The trier of fact also could conclude that, in doing so, Blue Shield was guilty of oppression -- i.e., "despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights" (Civ. Code, § 3294, subd. (c)(2)) -- because its rescission of the plan contract caused Callil to be personally liable for more than $50,000 in medical bills that she incurred with the belief that her medical costs were covered.[8] Therefore, Blue Shield is not entitled to summary adjudication of the punitive damages claim.

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[8] Although Callil argues in her appellant's reply brief that she is entitled to punitive damages based upon Blue Shield's alleged pattern of engaging in postclaims underwriting, there is no evidence in the record to support this argument. Her citation to purported evidence that Blue Shield consistently fails to complete medical underwriting actually cites to her brief in her opposition to the summary judgment motion, which in turn cites to evidence submitted in support of her motion for summary adjudication, which is not included in the record on appeal.

DISPOSITION

The judgment is reversed. Callil shall recover her costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

WILLHITE, J.

We concur:

EPSTEIN, P. J.

MANELLA, J.