UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

ANNA MOHR, SAMANTHA SOHMER, and CHARLES WILTSIE, Individually and on Behalf of All Others Similarly Situated, Plaintiffs, vs. UNITEDHEALTH GROUP INCORPORATED, UNITEDHEALTHCARE, INC., UNITED HEALTHCARE SERVICES, INC., UNITEDHEALTHCARE INSURANCE COMPANY, OXFORD HEALTH INSURANCE, INC., and UNITEDHEALTHCARE COMMUNITY PLAN, INC., Defendants.	Civil No. CLASS ACTION **COMPLAINT** DEMAND FOR JURY TRIAL

Plaintiffs, Anna Mohr, Samantha Sohmer, and Charles Wiltsie ("Plaintiffs"), by their undersigned attorneys, allege the following based upon their knowledge as set forth herein and upon information and belief. Further additional evidence supporting the claims set forth herein can be obtained after a reasonable opportunity for discovery.

INTRODUCTION

1. Defendant UnitedHealth Group Inc. ("UnitedHealth Group") — through its wholly-owned subsidiaries, including Defendants UnitedHealthcare, Inc. ("UHC"), United Healthcare Services, Inc. ("UHC Services"), UnitedHealthcare Insurance Company ("UHI"), Oxford Health Insurance, Inc. ("OHI"), and UnitedHealthcare Community Plan, Inc. ("UCP"), is a fully integrated health insurance company.

2. Plaintiffs, who received prescription drug benefits through health insurance policies either purchased directly or issued by Defendants to their employers, bring this action on behalf of themselves and a class and subclasses of similarly situated persons alleging (a) violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), (b) violations of state law and (c) violations of the Racketeering Influenced and Corrupt Organizations Act ("RICO").

3. Defendants and/or their agents required network pharmacies to charge insured patients unauthorized and excessive amounts for prescription drugs. Defendants and/or their agents "clawed back" these excessive payments by forcing the pharmacies to pay the unauthorized and excessive charges to Defendants and/or their agents after collecting them from the insureds.

4. As an example, based on information from one investigation, a member of the Class (defined below) paid a $50.00 "co-payment" to purchase a drug known as Sprintec. By way of this unlawful scheme, Defendants and/or their agents contracted with the pharmacy to pay the pharmacy only $11.65 for that Sprintec prescription. Unknown to and hidden from the Class members at the time, Defendants and/or their agents required the pharmacy to (1) collect the $50.00 "co-payment" from the insured patient and then (2) pay to Defendants the unlawful $38.85 "Spread" between the supposed "co-payment" and Defendants' actual cost of the drug. The secret payment of the "Spread" to the Defendants and/or their agents is known as a "Clawback." The transaction is graphically depicted as follows:

Price Charged by Pharmacy	$	10.04
Pharmacy's Fee	$	1.00
Tax	$	0.65
Total Cost (Cost+Fee+Tax)	**$**	**11.65**
Co-Payment	$	50.00
Difference Pocketed by Defendants	**$**	**(38.35)**

CLAWBACK

5. Since Defendants were already fully compensated for providing prescription drug benefits through the health insurance premiums that they were paid for the health insurance policies, their taking of additional, undisclosed Spread compensation was improper and illegal under ERISA and RICO. Further, under the nationwide, materially uniform language in Defendants' health insurance policies, Defendants scheme to obtain additional, undisclosed compensation is a breach of those policies, a breach of the covenant of good faith and fair dealing and a violation of the principles of fair trade practices. Alternatively, Defendants have been unjustly enriched through their Spread and Clawback scheme.

6. In short, under Defendants' scheme as illustrated in this actual example, the prescription "co-payment" is not a "co-" payment for at least two reasons: (1) a material portion of the payment is not even a payment ***for a prescription drug*** — it is a hidden additional premium payment to the insurance company and/or its PBM and (2) it is not a "co-" payment for a prescription drug because the insurer is paying nothing, but instead is getting a material portion the insured's payment funneled back to it in secret. Despite the fact that co-payments are defined in the policy section entitled "Cost-Sharing," there is no

sharing of costs between the insured and the insurer when there is a Spread and/or a Clawback. It is not a "co-payment," it is a "you-payment."

7. With regard to ERISA, under Count I, ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring an action to enforce his rights under the terms of the plan. Defendants have violated the terms of the plan by establishing the Spread and taking illegal Clawbacks as alleged below.

8. Under Count II, ERISA § 406(a), 29 U.S.C. § 1106(a), provides that a party in interest shall not receive direct or indirect compensation unless it is reasonable. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants received unreasonable compensation.

9. Under Count III, ERISA § 406(b), 29 U.S.C. § 1106(b), provides that a fiduciary shall not deal with plan assets in its own interest or for its own account, or receive any consideration for its own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants received plan assets and consideration for their personal accounts in violation of this provision.

10. Under Count IV, ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), provides that a fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan, and with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the

conduct of an enterprise of a like character and with like aims. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants have breached their fiduciary duties.

11. Under Count V, ERISA § 702, 29 U.S.C. § 1182, prohibits Defendants from discrimination and requiring discriminatory premiums and contributions based on health factors. Defendants have unlawfully discriminated against plan participants who utilize prescription drugs subject to the Spreads and Clawbacks for the treatment of their health conditions as compared to other similarly situated plan participants.

12. Under Count VI, ERISA § 405(a), 29 U.S.C. § 1105(a), imposes liability on a fiduciary, in addition to any liability which it may have under any other provision, for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it knows of a breach and fails to remedy it, knowingly participates in a breach, or enables a breach. The Defendants breached all three provisions.

13. Under Counts VII and VIII, Defendants have breached their health insurance policies by charging Spread and taking Clawbacks and are liable for all damages suffered as a result of their breaches of contract.

14. Under Counts IX and X, Defendants have breached the duty of good faith and fair dealing by charging Spread and taking Clawbacks and are liable for all damages suffered as a result of these breaches.

15. Under Counts XI, XII and XIII, Defendants have committed unfair trade practices by charging undisclosed Spread and taking undisclosed Clawbacks and are liable for all statutory remedies.

16. Under Counts XIV and XV, Defendants have been unjustly enriched by charging Spreads and taking Clawbacks and are liable for all amounts in which they were unjustly enriched.

17. Under Count XVI, Defendants have violated RICO as alleged below and are liable for all statutory remedies.

JURISDICTION

18. This court has subject matter jurisdiction over this action pursuant to (a) 28 U.S.C. §1331, which provides for federal jurisdiction over civil actions arising under the laws of the United States; (b) 29 U.S.C. §1132(e)(1) providing for federal jurisdiction of actions brought under Title I of ERISA; and (c) 18 U.S.C. § 1964 providing for federal jurisdiction to prevent and restrain violations of 18 U.S.C § 1962. This court also has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332(d) because the matter in controversy exceeds the sum or value of $5,000,000, exclusive of interest and costs, and is a class action in which a member of the class is a citizen of a State different from any of the Defendants.

PARTIES

19. Plaintiff Mohr is a citizen and resident of New York and is covered by an OHI health plan, a fully insured health plan provided through her employer. Mohr received prescription drug coverage under a UnitedHealthcare/Oxford "G PPO 25/40 F NG OHI" PPO group policy purchased through her employer for her benefit. This policy is a welfare benefit plan subject to ERISA. Upon information and belief, Mohr's plan was serviced and administered by UHC Services. Under the policy, Plaintiff Mohr was obligated to pay co-

payments of $10-$75 per prescription for certain categories of drugs, and co-payments of $25-$187.50 after payment of the $100 deductible for other categories of drugs.

20. Plaintiff Sohmer is a citizen and resident of New Jersey and is covered by an UHI health plan, a fully insured health plan provided through her employer. Sohmer received prescription drug coverage under a "Choice Plus Plan A" group policy purchased through her employer for her benefit. This policy is a welfare benefit plan subject to ERISA. Upon information and belief, Sohmer's plan was serviced and administered by UHC Services. Under the policy, Plaintiff Sohmer was obligated to pay co-payments of $10-$75 per prescription for certain categories of drugs, and co-payments of $37.50-$175.

21. Plaintiff Wiltsie, a citizen and resident of Taylor, Michigan, is a policyholder of a health insurance policy issued by UCP. Wiltsie and his wife are insureds under the UnitedHealthcare "Gold Compass 500" HMO. Upon information and belief, Wiltsie's plan was serviced and administered by UHC Services. Under the policy, Plaintiff Wiltsie was obligated to pay co-payments of $5-$40 per prescription for certain categories of drugs, and co-insurance of 20% -30% after payment of a deductible for other categories of drugs.

22. Defendant UnitedHealth Group is a U.S. diversified managed healthcare company with its principal place of business in Minnetonka, Minnesota. In 2015, UnitedHealth Group reported revenue in excess of $157 billion, and the company is currently ranked sixth on the Fortune 500. UnitedHealth Group offers a spectrum of products and services through its two operating platforms: health insurance benefits

through UnitedHealthcare including prescription drugs through Defendants' pharmacy benefits manager ("PBM"), Optum.[1]

23. Defendant UHC, a wholly-owned subsidiary of UnitedHealth Group with its principal place of business in Minnesota, provides health care benefits to a full spectrum of customers and markets through UnitedHealthcare Employer & Individual (which serves employers, students and other individuals, and active and retired military and their families through the TRICARE program), UnitedHealthcare Medicare & Retirement (for Medicare beneficiaries and retirees), UnitedHealthcare Community & State (for state Medicaid and community programs and their participants), and UnitedHealthcare International.

24. Defendant OHI, a wholly-owned subsidiary of UnitedHealth Group, is a licensed health insurance company incorporated in New York and with its principal place of business in Trumbull, Connecticut.

25. Defendant UHI, a wholly-owned subsidiary of UnitedHealth Group, is a licensed health insurance company incorporated in Connecticut with its principal place of business in Hartford, Connecticut.

[1] Non-party Optum is UnitedHealth Group's wholly-owned PBM. Optum provides pharmacy care services to more than 66 million people in the United States through its network of more than 67,000 retail pharmacies and multiple home delivery facilities throughout the country. Optum provides pharmacy care services to a substantial majority of UnitedHealthcare members. Because Optum is a wholly-owned subsidiary of UnitedHealth Group, its financial results are included in UnitedHealth Group's Consolidated Financial Results.

26. Defendant UHC Services, a wholly-owned subsidiary of UnitedHealth Group, is a Minnesota corporation with its principal place of business in Minnesota. Through and in combination with its state-level UHC/OI subsidiaries/affiliates/agents, it administers health insurance policies for Defendants.

27. Defendant UCP, a wholly owned subsidiary of UnitedHealth Group, is a provider of health plans in the United States. UCP is a Michigan corporation with its headquarters in Southfield, Michigan. UCP was formerly known as UnitedHealthcare Great Lakes Health Plan, Inc. and changed its name to "UnitedHealthcare Community Plan, Inc." in January 2012.

SUBSTANTIVE ALLEGATIONS

Health Insurance in General in the United States

28. Health insurance is paid for by a premium paid to health insurers for medical and prescription drug benefits for a defined period. Premiums can be paid by individuals, employees, unions, employers or other institutions.

29. If a health insurance policy covers outpatient prescription drugs, the cost for prescription drugs is often shared between the insured patient and the insurer. Such cost sharing can take the form of deductible payments, co-insurance payments and co-payments. In general, deductibles are the dollar amounts the insured pays during the benefit period (usually a year) before the insurer starts to make payments for drug costs. Co-insurance requires an insured person to pay a stated percentage of drug costs, often after exhausting the deductible limit. Co-payments are fixed dollar payments made by an insured patient toward drug costs.

The Pharmacy Benefits Industry and Pharmacy Benefits Managers

30. The pharmaceutical benefits industry consists of complex arrangements between numerous entities, including, but not limited to, drug manufacturers, drug wholesalers, pharmacy benefit managers ("PBMs"), pharmacies, health insurance companies, employers and insureds.

31. On the drug distribution side of the market, the drug manufacturer typically sells drugs to a drug wholesaler, which then in turn sells the drugs to a retail pharmacy. Payments for the drugs in turn go from the retail pharmacy to the wholesaler and to the manufacturer. The retail pharmacy then distributes drugs to insured patients from its inventory. Neither the PBM nor the insurer is involved in the distribution of prescription drugs.

32. The retail payment side of the market for drugs covered by insurance is largely controlled by insurance companies and their contracted or owned PBMs. In most instances where a health insurance policy provides prescription drug benefits, a PBM is the agent of the insurance company hired to administer the prescription drug component of a health insurance policy. For example, Optum acted as the agent of Defendants in administering Defendants' prescription drug plans.

33. According to the Pharmaceutical Care Management Association, PBMs manage pharmacy benefits for 266 million Americans as of 2016. They may operate as part of integrated retail pharmacies (*e.g.*, CVS Health and Caremark) or as part of health insurance companies (*e.g.*, UnitedHealth Group and Optum).

34. The three largest public PBMs are Express Scripts, CVS Caremark, and UnitedHealth Group's own PBM, Optum. These three companies manage the pharmacy benefits of approximately 75% of the market, and cover 180 million enrollees.

35. When a patient presents a prescription at a pharmacy, key information such as the patient's name, drug dispensed and quantity dispensed is transmitted via interstate wire to a "switch" that then directs the information to the correct PBM. The PBM instantaneously processes the claim according to the benefits plan assigned to the patient. The PBM electronically transmits via interstate wire a message back to the pharmacy indicating whether the drug and patient are covered and, if so, the amount the pharmacy must collect from the patient as a co-payment, co-insurance, or to be paid toward a deductible.

36. The PBM is supposed to pay the pharmacy any amounts owed to the pharmacy over the co-payment, co-insurance or deductible amount paid by the patient approximately every two weeks for the claims that were processed by any given pharmacy in the prior two-week period.

37. If the patient's payment is greater than the amount that the insurer or its PBM has negotiated to pay the provider pharmacy, however, there will be a "negative reimbursement" to the pharmacy for the "Spread" between the patient's payment and the actual cost of the drug to the insurer or its PBM.

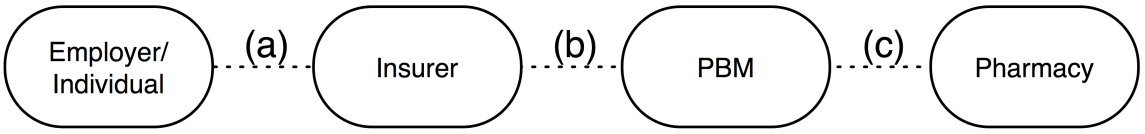
38. The "negative reimbursement" is paid by the pharmacy to Defendants as part of the reconciliation every two weeks.

39. This payment of a "Spread" to the insurer and/or its PBM — referred to in the industry as a "Clawback" — evidences the overcharge to the insured.

The Patient–Insurer–PBM–Pharmacy Contractual Relationships

40. Contractual relationships exist between the employer (or individual) and the health insurance company; the health insurance company and the PBM; and the PBM and the pharmacy. As alleged above, an employer buys a health insurance policy from a health insurance company to provide prescription drug benefits for its employees. Health insurance companies then hire PBMs to manage the prescription drug benefits offered pursuant to their policies.

41. The following diagram represents (in simplified form) the contractual relationships existing between the insured patient and the pharmacy:



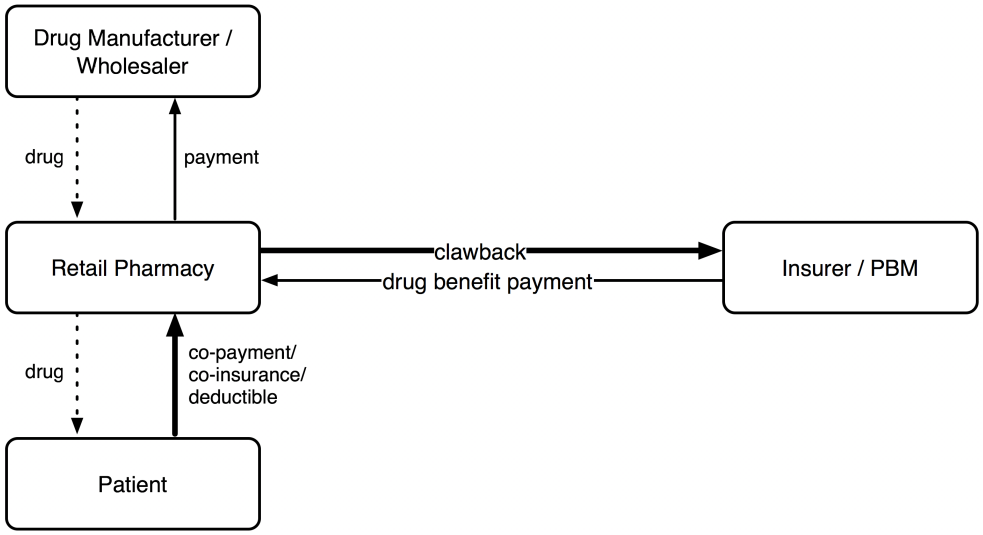
(a) **Employer/Individual–Insurer Agreements (*i.e.*, Insurance Policies).** Employers and individuals buy health insurance policies to provide prescription drug benefits. These policies contain uniform provisions that set forth key plan terms such as the mechanism for and amount of the deductible, co-payment, and/or co-insurance that a patient must pay to obtain prescription drug benefits. Plaintiffs and Class members are intended beneficiaries of such agreements.

(b) **Insurer–PBM Agreements**. Health insurance companies, such as Defendants, contract with and/or own PBMs, which act as their agents to administer the

prescription drug benefits purchased through the health insurance policies that the insurers issue.

(c) **PBM–Pharmacy Agreements**. PBMs in turn, contract with pharmacies, which serve as providers in the insurers' pharmacy network. The pharmacies fill prescriptions that are health benefits covered under the insurers' policies. Pursuant to these agreements, the PBMs set the amount that a pharmacy will collect from an insured patient for a prescription drug, the amount the PBM (and insurer) will pay the pharmacy for filling the patient's prescription, and the amount of the insured's payment that the pharmacy must send to the PBM as a "Clawback." On information and belief, the pharmacy has no role in setting the amount of the patient's payment and thus must accept the "Clawback" amount as determined by the PBM.

42. The relationship among the parties is shown graphically as follows:



43. Pursuant to the health insurance policies, insurers must ensure that, when they contract with a PBM to act as their agent to manage prescription drug benefits under

the health insurance policies, the PBM follows the policies' terms, such that subscribers are not overcharged for their prescription drug benefits.

44. To the contrary, PBMs, acting as agents and/or in concert with health insurance companies, routinely charge insureds substantially higher prices for prescription drugs than are allowed under the health insurance policies.

Defendants' Insured Patients Pay Undisclosed, Unauthorized and Excessive Fees for Prescriptions Drugs

45. The Defendants in this case have taken the general employer-insurer-PBM-pharmacy structure and, through various agreements, created their unlawful scheme. Under these agreements, the pharmacy charges the insured patients a prescription drug price that is set by the PBM and/or insurer, which price typically is based on a percentage of the so-called average wholesale price or "AWP" (the "Insureds' Price").[2] Alternatively, the pharmacy charges the insured patients a co-payment, which also is set by the Defendants and/or their agent PBMs.

46. The Insureds' Price or co-payment routinely is higher than the price the PBM pays the pharmacy for providing the drug to the insured patients — particularly for many low-cost, high volume generic prescription drugs, although some brand drugs are also subject to "Clawbacks."

[2] Average Wholesale Price is an amount set by the prescription drug manufacturers that rarely, if ever, reflects a true price charged in wholesale transactions.

47. Moreover, under the confidentiality provisions of the PBM-Pharmacy Agreements, pharmacies cannot tell patient insureds that they are being overcharged, much less sell drugs to them at a lower price separate and apart from the insurance policies.

48. In summary, the PBM–Pharmacy Agreements: (1) require pharmacies to charge insureds more for drugs than the Defendants and their PBM pay the pharmacies, with the difference between the two amounts known as the "Spread;" (2) require the pharmacies to collect the "Spread" from patient insureds; (3) require payment of Spread or deduction of the "Spread" from future reimbursement to the pharmacy by the PBM as a "Clawback;" (4) prohibit pharmacies from disclosing to insureds the existence or amount of the "Spread" and "Clawback;" (5) prohibit pharmacies from disclosing to insureds that they can purchase drugs at lower prices; and (6) prohibit pharmacies from selling to insureds covered prescription drugs at prices that are lower than the price that the insurer/PBM orders the pharmacies to charge the insureds. Instead, the "Spread" and "Clawback" overcharges are pocketed secretly and unlawfully by the insurance companies and/or their agents.

49. There are several ways in which Defendants operate this overcharge scheme. For example:

(a) A patient under one of Defendants' health insurance policies went to a pharmacy to purchase Lisinopril — a common, generic ACE inhibitor used to treat high blood pressure. According to Defendant's uniform health insurance policy language, the insured should have paid the ***lower of*** (1) the co-payment or co-insurance, (2) the "allowed amount" (or "eligible expenses"), which is defined as the contracted fee between the

insurer (or its agent PBM) and the pharmacy, or (3) the "Usual and Customary Charge" that the pharmacy would charge a customer who does not have insurance.

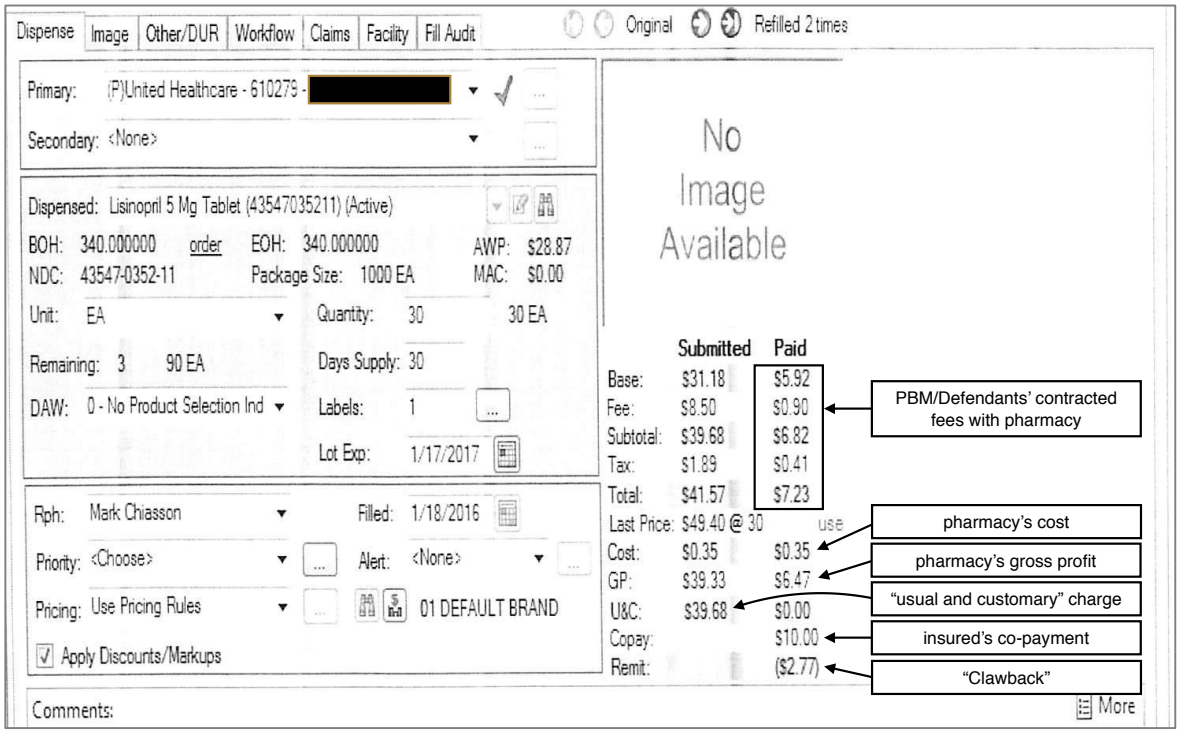
(b) In this documented instance, Lisinopril was purchased by the pharmacy from the manufacturer or wholesaler for $0.35. Pursuant to the PBM–Pharmacy Agreement, the PBM paid the pharmacy $5.92 for the drug, a fulfillment fee of $0.90, and $0.41 in tax. Accordingly, pursuant to the PBM–Pharmacy Agreement, the contracted fee between the PBM and the pharmacy was $7.23 for the prescription.

(c) Despite this, pursuant to the PBM–Pharmacy Agreement, the PBM required the pharmacy to charge the insured a $10.00 "co-payment" for the Lisinopril, even though the "allowed amount" (or "eligible expenses") (the contracted fee between the PBM and the pharmacy) was only $7.23, which was less than the required "co-payment" and was the "lower" amount that the insured should have paid under the policy. Moreover, the "co-payment" was not a payment made by the insured *in addition* to an amount paid by the insurer and/or PBM for the Lisinopril, as the plain meaning of the prefix "co-" required.

(d) The PBM–Pharmacy Agreement then required the pharmacy to pay to the PBM/insurer the "Spread" between the "allowed amount" (or "eligible expenses") and the "co-payment" amount collected from the insured — a $2.77 "Clawback."

(e) On information and belief, the PBM–Pharmacy Agreement further prohibited the pharmacy from disclosing the "Clawback" to the insured or from selling the drug to the insured for less than the $10 "co-payment" separate and apart from the policy.

(f) The above-described transaction is set forth below in an annotated excerpt of an actual transaction record from an investigation into this scheme.[3]



50. Alternatively, where the insured patient pays a deductible and/or co-insurance (not a co-payment), the patient is overcharged because his or her payment is based on the inflated amount that the PBM requires the pharmacy to charge the customer, ***not*** the lower amount that the Defendants and PBM pay to the pharmacy.

51. For example, the insurer/PBM could set the amount that the pharmacy must charge the insured patient for Lisinopril at $15.00, but the insurer/PBM would pay the pharmacy only $7.23. Under the full deductible portion of a plan, the patient insured pays $15.00, the pharmacist keeps $7.23, and the pharmacy is forced to pay the PBM/insurance

[3] A number of records from the investigation, including this Lisinopril transaction, are attached in full at Exhibit A.

company a "Clawback" of $7.77.[4] Under a co-insurance plan, the insured patient would pay a percentage of $15 rather than a percentage of $7.23, with the difference being subject to a Clawback.

The Fox 8 Investigation

52. The New Orleans television station FOX 8 investigated "Clawbacks," including "Clawbacks" by Defendants, as part of its Medical Waste investigative series. FOX 8 found that insurance companies were "charging co-pays that exceed the customers' costs for the drug," and that insurers were "clawing back" the excess payments from the customers.

53. FOX 8 found that pharmacists were required to charge customers the amount dictated by the insurer or PBM, and were not allowed to give any discounts. According to Randal Johnson, president and CEO of the Louisiana Independent Pharmacies Association, "it's actually costing you more to acquire the drug with your insurance than you could if you walked in off the street and you didn't have insurance."

54. More egregious, according to FOX 8, pharmacists were barred from disclosing that additional savings could be achieved by purchasing drugs directly and not applying the claims to the insurance coverage.

[4] This overcharge scheme is contrary to the way that insurer/PBMs charge the government under Medicare Part D, which is consistent with Defendant's uniform policy language and notions of fair dealing and fair trade for co-payments, deductibles and co-insurance. The prices that Medicare enrollees pay pursuant to Part D are based on the net price actually paid to the pharmacy. *See* 42 C.F.R. § 423.100 ("the amount such network entity will receive, *in total*, for a particular drug").

55. FOX 8 identified Defendants, acting through their PBM, Optum, as a prime offender.

56. FOX 8 published a number of "screenshots" from a pharmacist's computer system showing, with respect to particular drugs, the amount of the co-payment Defendants required pharmacists to collect from customers and the amount the pharmacists were required to pay to Defendants as a "Clawback." The Lisinopril example set out above is taken from one of the screenshots.

57. Similarly, on January 19, 2016, a pharmacist collected a co-payment of $10 for a prescription of Meloxicam on which it paid an undisclosed "Clawback" of 80 cents to Defendants.[5]

58. On September 16, 2015, a pharmacist collected a co-payment of $15 for a prescription of Oxybutynin on which it paid an undisclosed "Clawback" of $2.58 to Defendants.

59. On November 10, 2015, a pharmacist collected a co-payment of $15 for a prescription of Venlafaxine on which it paid an undisclosed "Clawback" of $1.37 to Defendants.

60. On January 6, 2016, a pharmacist collected a co-payment of $10 for a prescription of Tizanidine on which it paid an undisclosed "Clawback" of $1.21 to Defendants.

[5] The transaction records for each of the transactions described here, and each involving Defendants, are set forth in Exhibit A.

61. On August 25, 2016, FOX 8 reported that Defendants, through Optum, admitted that they had "an 'overpayment program.'" According to Doug Hoey of the National Pharmacists Association, "[t]he hand in the cookie jar has been caught."

62. Defendants then stated that they would "update our plans to ensure UnitedHealthcare members pay the lowest price at the pharmacy."

"Clawbacks" Are Most Common With Widely Used Drugs

63. Defendants impose "Clawbacks" most frequently on widely used, low-cost drugs, and particularly generic drugs, where the cost of the drug is relatively low. This enables Defendants to impose deductible costs, co-payments and co-insurance costs that are higher than the cost of the drug, thereby insuring for themselves a "Clawback." These commonly used drugs include, but are not limited to: Alprazolam, Amoxicilin, Bactrim, Buspirone, Ciprofloxacin, Clonazepam, Diazepam, Flonase, Fluoxetine, Fluticasone, Invokamet, Lamotrigine, Lexapro, Lisinopril, Meloxicam, Nitrofurantoin, Oxybutynin Percocet, Sprintec, Tamiflu (Oseltarmivir), Tizanidine, Valsartan, Venlafaxine and Ventolin.

Defendants' Policies with Plaintiffs and the Class

64. Health insurance policies are subject to state regulation. The policy forms typically must be filed with and approved by the appropriate state regulators.

65. Because they are approved form policies, the relevant terms of the Policies insuring Plaintiffs and Class members are substantively the same. For this reason, upon information and belief, the contractual rights relevant to the claims alleged herein are shared by all members of the Class.

66. Defendants provide to their customers a summary of benefits as the primary source of information concerning prescription drug coverage ("Policy Summary").[6] The Policy Summary states that if customers want to see the underlying Policy to obtain more detailed information, they must consult Defendants' websites or call Defendants' toll free numbers.

67. The Policies state that Defendants will provide health insurance benefits for "covered health services."

68. In exchange for these health benefits, including prescription drug benefits, Defendants are paid a "Premium," a periodic fee.

69. "Covered health services" or "covered services" are health services, which Defendants determine to be, inter alia, "medically necessary" and covered by the policy. The prescription drugs purchased by Plaintiffs and Class members are "covered health services" under the Policies.

70. Plaintiffs and other customers contribute to the cost of prescription drugs under the policies in three ways — through the payment of co-insurance, a deductible or a co-payment.

The Co-insurance Provisions

71. Pursuant to a typical Policy Summary provided by Defendants to Plaintiffs and Class members, "**Co-insurance** is *your* share of the costs of a covered service,

[6] Insurers generally use the same form definitions. For example, the material definitions are identical in both Defendant's Summary of Benefits and Coverage and in Aetna's Connecticut Summary of Benefits and Coverage.

calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**." (emphasis in original.)

72. The "allowed amount" (sometimes referred to as "eligible expenses") is the maximum amount that Defendants determine they will pay for covered services (*i.e.*, Benefits).

73. When "covered services" like prescription drugs are received from a participating pharmacy (sometimes referred to as a "Network provider" or "Participating Provider"), the "allowed amount" (or the "eligible expenses") is "the amount [Defendants] have negotiated with the Participating Provider" – the amount the insurance company pays the pharmacy for the drugs.

74. Under the Policy itself, co-insurance is stated as a percentage of the "allowed amount" (or "eligible expenses") for covered services.

75. Accordingly, under the Co-insurance provisions, the patient should pay a percentage of the amount Defendants actually pay the pharmacy for a drug.

The Co-payment Provisions

76. Pursuant to a typical Policy Summary provided by Defendants to Plaintiffs and Class members, "**Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service."

77. Under the Policies, the Co-payment paid by insureds is defined as ***the lesser of*** a fixed amount that insureds are required to pay for certain covered services (e.g., $15)

or the "allowed amount" (or "eligible expenses"). Since, as set forth above, the "allowed amount" (or "eligible expenses") is the amount Defendants pay the pharmacy for each prescription drug purchased by a customer, that is the amount a customer should pay for a prescription drug if it is less than the co-payment amount.

78. Moreover, for prescription drugs purchased at a retail network pharmacy, the patient is responsible for paying the lower of: the applicable Co-payment or the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

79. Accordingly, a "co-payment" is the lesser of (1) the fixed-dollar amount of the co-payment, (2) the "allowed amount" (or "eligible expenses"), which is the amount the insurer/PBM pays to the pharmacy or (3) "the Usual and Customary Charge" that the pharmacy would charge a customer who did not have insurance.

The Deductible Provisions

80. Pursuant to a typical Policy Summary provided by Defendants to Plaintiffs and Class members, "[y]ou must pay all the costs up to the deductible amount before this plan begins to pay for the covered services you use."

81. Under the deductible provision, the amount that an insured should pay under the form policy for a drug, and the amount that should be applied to the annual deductible, is "allowed amount" (or "eligible expenses").

82. The annual deductible does not include, and an insured should not pay, any amount that exceeds the "allowed amount" (or "eligible expenses").

83. Accordingly, as with Co-payments and Co-insurance, the amount the customer pays, and the amount applied against the deductibles, is determined by the

"allowed amount" (or "eligible expenses") — the amount Defendants or its agent PBM pay the pharmacy for each prescription drug purchased by an insured.

Plaintiffs' Purchases

84. During the time that Plaintiffs were covered by the Defendants' policies, Plaintiffs purchased prescriptions drugs for which they were required to make co-payments, co-insurance, and/or deductible payments, including those specifically alleged above.[7] Upon information and belief based on the fact that Plaintiffs purchased drugs for which Defendants overcharge customers, Plaintiffs were charged fees for prescription drugs in excess of the fees permitted by their health policy.

85. Plaintiff Mohr's purchases of such prescription drugs pursuant to her health insurance policy include, but are not limited to, purchases from BJs Drugs in Forest Hills, New York on the following dates: July 18, 2011; September 12, 2011; October 24, 2011; November 15, 2011; November 28, 2011; December 31, 2011; January 31, 2012; March 3, 2012; April 7, 2012, May 3, 2012; June 1, 2012; June 15, 2012; July 5, 2012; August 3, 2012; September 5, 2012; October 27, 2012; November 14, 2012; December 1, 2012; December 22, 2012; December 24, 2012; January 14, 2013; January 22, 2012; January 1, 2013; March 4, 2013; March 16, 2013; March 29, 2013; April 3, 2013; April 8, 2013; April 25, 2013; May 18, 2013; June 15, 2013; July 13, 2013; September 9, 2013; October 9, 2013; November 9, 2013; December 5, 2013; December 14, 2013; January 11, 2014;

[7] For confidentiality reasons, Plaintiffs have not specified the drugs they purchased, but if relevant, they will disclose such information during discovery after entry of an appropriate protective order.

January 18, 2014; February 11, 2014; March 5, 2014; April 15, 2014; April 30, 2014; May 13, 2014; June 7, 2014; June 25, 2014; July 28, 2014; August 25, 2014; October 6, 2014; December 1, 2014; January 8, 2015; February 3, 2015; March 16, 2015; April 16, 2015; April 20, 2015; May 6, 2015; May 23, 2015; July 2, 2015; August 10, 2015; September 1, 2015; September 8, 2015; October 2, 2015; October 30, 2015; March 10, 2016; April 12, 2016; June 7, 2016; July 26, 2016; and August 31, 2016.

86. Plaintiff Sohmer's purchases of such prescription drugs pursuant to her health insurance policy include, but are not limited to, purchases from ShopRite Pharmacy in Parsippany, New Jersey, on the following dates: December 20, 2013; October 7, 2014; December 1, 2014; March 23, 2015; July 18, 2015; and February 10, 2016.

87. Plaintiff Wiltsie's purchases of such prescription drugs pursuant to his health insurance policy include, but are not limited to, purchases from Par Wick Pharmacy in Taylor, Michigan, on the following dates: March 10, 2015; June 1, 2015; September 11, 2015; October 14, 2015; November 9, 2015; December 9, 2015; January 6, 2016; March 5, 2016; March 31, 2016; April 27, 2016; May 25, 2016; June 24, 2016; July 15, 2016; August 25, 2016; and September 20, 2016.

Defendants Acts Were Knowing, Intentional and In Violation of a Prior Court Order

88. Defendants' unlawful scheme alleged herein is not the first time that UnitedHealthcare has engaged in this kind of misconduct against its insureds. In 2000, a case was brought in this district against two of the Defendants in this case. In that case, *Smith, et al v. United Healthcare Services, Inc. et al*. Case No. 00-cv-1163-ADM-AJB,

plaintiffs alleged a copayment overcharge scheme that is materially identical to a central portion of the scheme alleged here. *See* First Amended Complaint, *Id*., ECF No. 99-1.

89. This Court granted summary judgment for plaintiffs in *Smith* on August 28, 2003. *See Smith v. United Health Services, Inc.,* 2003 WL 22047861 (D. Minn. Aug. 28, 2003). The Court's ruling included an interpretation of a key term that is materially identical to a term at issue in this case.

90. In *Smith*, Defendants' health insurance policies stated that the patient insured would pay the lesser of the co-payment or the "Prescription Drug Cost," which was defined as the "contracted reimbursement rate" between Defendants and the pharmacy dispensing the drug. *Id.* at * 2. According to this Court in rendering summary judgment for plaintiffs, the "contracted reimbursement rate" was the amount Defendants "repay[] the pharmacy for filling a given prescription drug." *Id*. at * 8.

91. The *Smith* case settled in 2004 through a court-approved settlement. The settlement contained an injunctive provision that required the language discussed above, or any "language substantially identical," to be "administered in accordance with the Court's Order of August 28, 2003," which was the summary judgment order. Stipulation of Settlement, Case No. 00-cv-1163 [ECF No. 102] at § 14.1.

92. The language of the contracts of Plaintiffs and the Class here are "substantially identical" to the policy language at issue in *Smith*. Whereas in *Smith*, patient insureds would pay the lesser of the Copayment or the Prescription Drug Cost, here patient insureds are to pay the lesser of the Copayment (or coinsurance or deductible amount), the "allowed amount" (or "eligible expenses") or the Usual and Customary Charge.

93. "Allowed amount" (or "eligible expenses") here, and Prescription Drug Cost in *Smith,* all are defined as the amount that Defendants have contracted to pay the pharmacy, which the *Smith* court stated succinctly is the amount that Defendants "repay[] the pharmacy for filling a given prescription drug." As set forth in the unlawful scheme alleged herein, therefore, Defendants are flagrantly violating the court-approved settlement in *Smith* by charging Plaintiffs and the Class members here Co-Payments that were and are higher than the amount that they "repay[] the pharmacy for filling a given prescription drug." Moreover, in changing the policy terms from 'Prescription Drug Cost" and "contracted reimbursement rate" to "allowed amount" (or "eligible expenses)," Defendants have knowingly, intentionally and deceptively attempted to circumvent the *Smith* summary judgment order and court-approved settlement in order to revive their unlawful scheme.

Defendants Are Fiduciaries And Parties In Interest

94. ERISA requires every plan to provide for one or more named fiduciaries who will have "authority to control and manage the operation and administration of the plan." ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1).

95. ERISA treats as fiduciaries not only persons explicitly named as fiduciaries under § 402(a)(1), 29 U.S.C. § 1102(a)(1), but also any other persons who in fact perform fiduciary functions. Thus, a person is a fiduciary to the extent "(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility

to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." ERISA § 3(21)(A)(i), 29 U.S.C. § 1002(21)(A)(i).

96. Defendants are fiduciaries for all of the plans to which they provided prescription drug benefits pursuant to Defendants' health insurance policies in that they exercised discretionary authority or control to:

(a) dictate the amount paid to pharmacies for prescription drugs;

(b) dictate the amount pharmacies charged insured patients for prescription drugs; (c) require pharmacies to charge insureds more for drugs than they paid the pharmacies, thereby creating and setting the amount of the "Spread;"

(c) require the pharmacies to collect the "Spread" from patient insureds;

(d) require pharmacies to pay the "Spread" to Defendants and require the deduction of the "Spread" from future reimbursements to the pharmacy as a "Clawback;"

(e) determine the amount of and require the collection of additional profits and compensation for services provided pursuant to the policies;

(f) misrepresent and fail to disclose to patient insureds the manner in which they charged for prescription drugs as alleged above;

(g) prohibit pharmacies from disclosing to patient insureds the existence or amount of the "Spread" and "Clawback;"

(h) prohibit pharmacies from disclosing to insureds that they can purchase drugs at a price lower than the amount set by Defendants under the policies;

(i) prohibit pharmacies from selling to insureds prescription drugs covered by the policies at prices that are lower than the prices that the insurer/PBM orders the pharmacies to charge the insureds; and

(j) manage the prescription drug benefit program, including processing and paying prescription drug claims.

97. The Spread is additional compensation for the provision of prescription drug insurance coverage that was collected by Defendants that was not either disclosed or agreed to.

98. Defendants exercised discretion to determine the amount of and require the payment of this additional undisclosed compensation.

99. Defendants are also parties in interest under ERISA in that they provided insurance services to each of Plaintiffs' and the Class members' health insurance plans and received direct and indirect compensation therefore. ERISA § 3(14)(B), 29 U.S.C. § 1002(14)(B).

100. Finally, even if Defendants are not fiduciaries or parties in interest, they are subject to equitable relief under ERISA, including surcharge and disgorgement.

Defendants ERISA Duties

101. **The Statutory Requirements:** ERISA imposes strict fiduciary duties upon plan fiduciaries. ERISA § 404(a), 29 U.S.C. § 1104(a), states, in relevant part, that:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of providing benefit to participants and their beneficiaries; and defraying reasonable expenses of administering the plan; with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man

> acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims; by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and Title IV.

102. **The Duty of Loyalty.** ERISA imposes on a plan fiduciary the duty of loyalty – that is, the duty to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ." The duty of loyalty entails a duty to avoid conflicts of interest and to resolve them promptly when they occur. A fiduciary must always administer a plan with an "eye single" to the interests of the participants and beneficiaries, regardless of the interests of the fiduciaries themselves or the plan sponsor.

103. **The Duty of Prudence.** Section 404(a)(1)(B) also imposes on a plan fiduciary the duty of prudence – that is, the duty "to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man, acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. . . ."

104. **The Duty to Inform.** The duties of loyalty and prudence include the duty to disclose and inform. These duties entail: (a) a negative duty not to misinform; (b) an affirmative duty to inform when the fiduciary knows or should know that silence might be harmful; and (c) a duty to convey complete and accurate information material to the circumstances of participants and beneficiaries.

105. **Co-Fiduciary Liability.** A fiduciary is liable not only for fiduciary breaches within the sphere of its own responsibility, but also as a co-fiduciary in certain circumstances. ERISA § 405(a), 29 U.S.C. § 1105(a), states, in relevant part, that:

> In addition to any liability which he may have under any other provision of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:
>
> (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; or
>
> (2) if, by his failure to comply with section 404(a)(1) in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or
>
> (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

106. **The Duty Not To Discriminate.** A health insurer may not discriminate against insureds by charging excessive premiums. ERISA §702 29 USC §1182, states in pertinent part:

> Prohibiting discrimination against individual participants and beneficiaries based on health status.
>
> (a) In eligibility to enroll.
>
> (1) In general. Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions. To the extent consistent with section 701, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction. For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions.

(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is

> greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

107. **Non-Fiduciary Liability.** Under ERISA, non-fiduciaries such as parties in interest like Defendants who knowingly participate in a fiduciary breach may themselves be liable for certain relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

Defendants Breached Their Duties

108. Defendants breached their insurance policies and legal obligations and harmed Plaintiffs and Class members in the following ways:

(a) Plaintiffs and Class members were charged unlawful fees and additional premiums for prescription drugs that substantially exceeded the fees paid by Defendants and/or their agent PBMs to the pharmacies for the dispensed drugs (i.e., "allowed amount" or "eligible expenses");

(b) Plaintiffs and the Class were charged "co-payments," a material portion of which were neither payments for prescription drugs nor were they "co-" payments made in conjunction with Defendants' payment for prescription drugs, as required by the plain language of form policy, but rather were undisclosed and unlawful payments and premiums to Defendants and its PBM;

(c) Plaintiffs and Class members were overcharged for co-insurance payments in that rather than paying a percentage of the fees that Defendants and/or their agent PBMs paid to the pharmacies for the dispensed drugs (i.e., "allowed amount" or

"eligible expenses"), the co-insurance payments were based on substantially inflated amounts;

(d) Plaintiffs and Class members were overcharged for prescription drugs on Copayment plans in that rather than paying the lesser of (1) the applicable co-payment, (2) the fee that the Defendants or their agent PBM paid to the pharmacy for the dispensed drug (i.e., "allowed amount" or "eligible expenses")) or (3) the "Usual and Customary Charge," Plaintiffs and Class members were charged a higher fee;

(e) Plaintiffs and Class members were overcharged when making payments toward their deductibles in that rather than paying the lesser of the applicable per occurrence deductible fee or the fee paid to the pharmacy for the dispensed drug, Plaintiffs and Class members were charged deductible fees that were higher;

(f) Defendants improperly processed and paid prescription drug claims;

(g) Defendants discriminated against patient insureds who were required to pay Spreads and Clawbacks;

(h) Defendants misrepresented and failed to disclose to patient insureds the manner in which they charged for prescription drugs as alleged above;

(i) Pharmacies were prohibited from disclosing to patient insureds the existence or amount of the "Spread" and "Clawback;" and

(j) Pharmacies were prohibited from disclosing to insureds that they could purchase drugs at a price lower than the amount set by Defendants under the policies and from selling drugs to customers at these lower prices.

109. Plaintiffs and Class members were overcharged for and/or paid unauthorized and excessive co-payments, co-insurance and deductible payments in connection with the purchase of numerous prescription drugs, including, but not limited to, the following: Alprazolam, Amoxicilin, Bactrim, Buspirone, Ciprofloxacin, Clonazepam, Diazepam, Flonase, Fluoxetine, Fluticasone, Invokamet, Lamotrigine, Lexapro, Lisinopril, Meloxicam, Nitrofurantoin, Oxybutynin Percocet, Sprintec, Tamiflu (Oseltarmivir), Tizanidine, Valsartan, Venlafaxine and Ventolin.

CLASS ACTION ALLEGATIONS

110. Plaintiffs bring this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of themselves and the Classes defined as follows:

> **Nationwide.** All insureds under Defendants' health insurance policies who purchased prescription drugs pursuant to such policies and paid an amount for such drugs that was set by Defendants (or their agents) that was higher than the amount provided by the health insurance policies (the "Class" or "Nationwide Class").

111. Within the Class there are three Subclasses:

(a) **ERISA**. All participants or beneficiaries of a welfare benefit plan health insurance policy provided by Defendants and subject to ERISA who purchased prescription drugs pursuant to such plan and paid an amount for such drugs that was higher than the amount provided by the health insurance policies (the "ERISA Subclass");

(b) **Non-ERISA**. All insureds under Defendants' non-ERISA health insurance policies issued in who purchased prescription drugs pursuant to such policies and paid an amount for such drugs that was set by Defendants (or their agents) that was higher than the amount provided by the health insurance policies (the "Non-ERISA Subclass");

(c) **Michigan**. All insureds under Defendants' non-ERISA health insurance policies issued in Michigan who purchased prescription drugs pursuant to such policies and paid an amount for such drugs that was set by

Defendants (or their agents) that was higher than the amount provided by the health insurance policies (the "Michigan Subclass").

112. The members of the Classes and each Subclass are so numerous that joinder of all members is impractical. Upon information and belief, there are tens of thousands of members in the Class and each Subclass.

113. Plaintiffs' claims are typical of the claims of the members of the Classes and Subclasses because Plaintiffs' claims, and the claims of all Class and Subclass members, arise out of the same conduct, policies and practices of Defendants as alleged herein, and all members of the Classes and Subclasses are similarly affected by Defendant's wrongful conduct.

114. There are questions of law and fact common to the Class and Subclasses and these questions predominate over questions affecting only individual Class and Subclass members. Common legal and factual questions include, but are not limited to:

(a) Whether Defendants are fiduciaries;

(b) Whether Defendants are parties in interest;

(c) Whether Defendants breached their fiduciary duties in failing to comply with ERISA as set forth above;

(d) Whether Defendants acts as alleged above breached ERISA's prohibited transaction rules;

(e) Whether Defendants breached ERISA § 702;

(f) Whether Defendants conducted the affairs of an enterprise through a pattern of racketeering activity;

(g) Whether such racketeering consisted of acts that are indictable pursuant to 18 U.S.C § 1341 and 1343;

(h) Whether Defendants engaged in a scheme to defraud;

(i) Whether each Defendant was a knowing and active participant;

(j) Whether the mail, interstate carriers or wire transmissions were used in connection with such scheme to defraud;

(k) Whether Plaintiffs and Class and Subclass members were injured in their property or business as a direct and proximate result of Defendants' racketeering activities;

(l) Whether Defendants breached their health insurance policies by authorizing or permitting pharmacies to collect and then remit "Spread" amounts to them and thereby overcharge subscribers for prescription drugs;

(m) Whether Defendants breached the covenant of good faith and fair dealing implied in the health insurance policies by authorizing or permitting pharmacies to collect then remit "Spread" amounts to them and thereby overcharge subscribers for prescription drugs;

(n) Whether Defendants violated relevant state laws prohibiting unfair trade practices, by overcharging insureds for prescription drugs;

(o) Whether Defendants were unjustly enriched by overcharging insureds for prescription drugs; and

(p) Whether the members of the Class and/or Subclasses have sustained damages and the proper measure of damages.

115. Plaintiffs will fairly and adequately represent the Class and Subclasses and have retained counsel experienced and competent in the prosecution of class action litigation. Plaintiffs have no interests antagonistic to those of other members of the Class and Subclasses. Plaintiffs are committed to the vigorous prosecution of this action and anticipates no difficulty in the management of this litigation as a class action.

116. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class and/or Subclass members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class and/or Subclass to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

117. Class action status in this action is warranted under Rule 23(b)(1)(A) because prosecution of separate actions by the members of the Class and Subclasses would create a risk of establishing incompatible standards of conduct for Defendant. Class action status is also warranted under Rule 23(b)(1)(B) because prosecution of separate actions by the members of the Class and Subclasses would create a risk of adjudications with respect to individual members of the Class and Subclasses that, as a practical matter, would be dispositive of the interests of other members not parties to this action, or that would substantially impair or impede their ability to protect their interests.

118. In the alternative, certification under Rule 23(b)(2) is warranted because Defendant has acted or refused to act on grounds generally applicable to the Class and

Subclasses, thereby making appropriate final injunctive, declaratory, or other appropriate equitable relief with respect to each Class and Subclasses as a whole.

119. In the alternative, certification under Rule 23(b)(3) is appropriate because questions of law or fact common to members of the Class and Subclasses predominate over any questions affecting only individual members, and class action treatment is superior to the other available methods for the fair and efficient adjudication of this controversy.

Exhaustion of Administrative Remedies Do Not Apply or Are Futile

120. Plaintiffs and the ERISA Subclass are not required to exhaust administrative remedies. Only a claim under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), could concern exhaustion of administrative remedies. Accordingly, only Count I is arguably implicated by that doctrine. Moreover, the exhaustion doctrine does not apply under that Count because Plaintiffs seek to enforce their rights under the terms of the plan not to recover benefits. Finally, because the injuries to Plaintiffs and the ERISA Subclass are part of a nationwide, clandestine, computerized scheme, any attempt to rectify the harm through administrative means would be futile and unnecessary.

121. This clawing back of payments (which directly evidences the overcharging of insureds) is pervasive and significantly increases the costs to patients across the country. Indeed, in a survey of community pharmacies conducted in June 2016 ("June 2016 Pharmacy Survey"), 49% of pharmacies surveyed stated that they have seen "Clawbacks" taking place between 10 and 50 times, and 35% of respondents answered that they have seen "Clawbacks" over 50 times in the past month.

122. Making matters worse, on information and belief, Insurer/PBMs contractually bind pharmacies to keep the Clawback scheme secret and they prevent pharmacies from informing patients that their drugs could cost less if the pharmacy were permitted to process the purchase outside of the patients' insurance plans. Put differently, if the patient in the Lisinoprol example above directly asked the pharmacist whether he or she could purchase Lisinopril outside of the insurance (*i.e.*, for less than the co-payment), the pharmacy would have been contractually prohibited from disclosing a lower available price or from selling the Lisinopril at that lower price — even if the pharmacy could do so at a profit. According to the June 2016 Pharmacy Survey, 39% of respondents answered that these gag-clause restrictions prevented them from informing patients about cheaper options between 10 and 50 times; and 19% of respondents answered that they were prevented by gag-clauses over 50 times from disclosing cheaper alternatives to patients.

123. Moreover, the overcharging and Clawback scheme is effectuated through a nationwide computer system. The computer systems that Defendants use to process claims often are not able to handle multiple prices for drugs and, rather than charging the client the proper lower price paid to the pharmacy, the claim adjudication system will automatically apply the higher price dictated by the insurer/PBM to charge the patient insured. Patients are never refunded the amount that they overpaid due to the failure of the adjudication system to handle multiple prices. Rather, that amount is kept by Defendants as a Clawback.

124. Finally, correcting the prices paid by patient insureds on an individualized basis would inevitably result in further unfair, disparate, and discriminatory treatment

among these ERISA Subclass members who have been reimbursed for the overcharges and those who have not.

125. For all of these reasons, it would be futile for Plaintiffs to demand administratively that Defendants modify the pervasive Spread and Clawback scheme that is ingrained in their business. To the extent that Defendants claim that Plaintiffs should exhaust an administrative remedy and the Court agrees, Plaintiffs reserve the right to seek a stay of this action while Plaintiffs engage in what they believe will be a futile exercise.

COUNT I

For Violations of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) on Behalf of the ERISA Subclass

126. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

127. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) provides that a participant or beneficiary may bring an action to enforce rights under the terms of the plan.

128. As set forth above, as a result of being overcharged for prescription drugs, Plaintiffs Mohr and Sohmer and the ERISA Subclass have been denied their rights under the policies to be charged a lower amount.

129. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged in the amount of the Spread compensation Defendants took for itself and are entitled to recover the amounts they have been overcharged.

130. Plaintiffs Mohr and Sohmer and the ERISA Subclass are entitled to enforce their rights under the terms of the plans and are entitled to an order providing, among other things:

(a) That they have been overcharged;

(b) For an accounting of Defendant's charges and overcharges;

(c) For payment of all amounts due them in accordance with their rights under the plans.

COUNT II

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
for Violations of ERISA § 406(a)(1)(C), 29 U.S.C. § 1106(a)(1)(C)
on Behalf of the ERISA Subclass

131. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

132. ERISA § 406(a)(1)(C), 29 U.S.C. § 1106(a)(1)(C), provides that a fiduciary shall not cause a plan to engage in a transaction if it knows that the transaction constitutes the payment of direct or indirect compensation in the furnishing of services by a party in interest to a plan.

133. Defendants are parties in interest under ERISA in that they provided insurance services to ERISA Subclass members pursuant to their prescription drug plans. ERISA § 3(14)(B), 29 U.S.C. § 1002(14)(B).

134. Defendants received direct and indirect compensation in the form of undisclosed Spread compensation in exchange for the health insurance services they

provided to Plaintiffs Mohr and Sohmer and the ERISA Subclass pursuant to their prescription drug plans.

135. The only exception to the prohibition of such compensation is if it was for services necessary for the operation of a plan and such compensation was reasonable. ERISA § 408(b)(2), 29 U.S.C. § 1108(b)(2).

136. The compensation paid to Defendants was not reasonable under ERISA § 408(b)(2), 29 U.S.C. § 1108(b)(2) in that the Spread compensation was excessive and unreasonable in relation to the value of the services provided in that it exceeded the premiums that were agreed upon for providing prescription drug benefits and which is reasonable compensation for such insurance services. Further, Defendants as fiduciaries of the plans are entitled to receive at most reimbursement for their direct expenses.

137. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged in the amount of the Spread compensation Defendants took for themselves.

138. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to: "(A) [ ] enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

139. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiffs Mohr and Sohmer and the Class, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) full disclosure of the foregoing acts and practices; or

(h) any other remedy the Court deems proper.

COUNT III

**ERISA § 502(a)(2) and (3), 29 U.S.C. § 1132(a)(2) and (3)
for Violations of ERISA § 406(b), 29 U.S.C. § 1106(b)
on Behalf of the ERISA Subclass**

140. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

141. ERISA § 406(b), 29 U.S.C. § 1106(b), provides that a fiduciary shall not deal with plan assets in its own interest or for its own account, or receive any consideration for its own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

142. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants received plan assets and consideration for their personal accounts.

143. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged and suffered losses in the amount of the Spread compensation Defendants took.

144. ERISA § 409, 29 U.S.C. § 1109, provides, *inter alia*, that any person who is a fiduciary with respect to a plan and who breaches any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA is subject to such other equitable or remedial relief as a court may deem appropriate.

145. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2) authorizes a plan participant to bring a civil action for appropriate relief under ERISA § 409, 29 U.S.C. § 1109. Section 409 requires "any person who is a fiduciary . . . who breaches any of the . . . duties imposed upon fiduciaries…to make good to such plan any losses to the plan. . . ."

146. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to: "(A) [ ] enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

147. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiffs Mohr and Sohmer and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) full disclosure of the foregoing acts and practices; or

(h) any other remedy the Court deems proper.

COUNT IV

**ERISA § 502(a)(2) and (3), 29 U.S.C. § 1132(a)(2) and (3)
for Violations of ERISA § 404, 29 U.S.C. § 1104
on Behalf of the ERISA Subclass**

148. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

149. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), provides that a fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan, and with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

150. ERISA § 409, 29 U.S.C. § 1109, provides, *inter alia*, that any person who is a fiduciary with respect to a plan and who breaches any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA is subject to such other equitable or remedial relief as a court may deem appropriate.

151. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants have breached their fiduciary duties.

152. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged and suffered losses in the amount of the Spread compensation Defendant took.

153. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2) authorizes a plan participant to bring a civil action for appropriate relief under ERISA § 409, 29 U.S.C. § 1109. Section 409 requires "any person who is a fiduciary . . . who breaches any of the . . . duties imposed upon fiduciaries…to make good to such plan any losses to the plan. . . ."

154. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to: "(A) [ ] enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

155. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiffs Mohr and Sohmer and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) full disclosure of the foregoing acts and practices; or

(h) any other remedy the Court deems proper.

COUNT V

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) for Violations of ERISA § 702, 29 U.S.C. § 1182 on Behalf of the ERISA Subclass

156. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

157. ERISA §702, 29 USC §1182, states in pertinent part:

> Prohibiting discrimination against individual participants and beneficiaries based on health status.
>
> (a) In eligibility to enroll.
>
> > (1) In general. Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:
> >
> > > (A) Health status.
> > >
> > > (B) Medical condition (including both physical and mental illnesses).
> > >
> > > (C) Claims experience.
> > >
> > > (D) Receipt of health care.
> > >
> > > (E) Medical history.
> > >
> > > (F) Genetic information.
> > >
> > > (G) Evidence of insurability (including conditions arising out of acts of domestic violence).
> > >
> > > (H) Disability.

> 2) No application to benefits or exclusions. To the extent consistent with section 701, paragraph (1) shall not be construed—
>
> > (A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or
> > (B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.
> > (3) Construction. For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions.

> (1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

158. In setting the amount of and taking excessive undisclosed Spread compensation, Defendants have required patient insureds who have paid excessive Spreads and Clawbacks to pay greater premiums and contributions than those patient insureds who have not paid excessive amounts for their health benefits.

159. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged and suffered losses in the amount of the Spread compensation Defendants took.

160. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to: "(A) [ ] enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

161. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiffs Mohr and Sohmer and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) full disclosure of the foregoing acts and practices; or

(h) any other remedy the Court deems proper.

COUNT VI

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
for Violations of ERISA § 405(a), 29 U.S.C. § 1105(a)
on Behalf of the ERISA Subclass

162. Plaintiffs Mohr and Sohmer incorporate by reference each and every allegation above as if set forth fully herein.

163. As alleged above, Defendants were fiduciaries within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). Thus, they were bound by the duties of loyalty, exclusive purpose, and prudence.

164. As alleged above, ERISA § 405(a), 29 U.S.C. § 1105(a), imposes liability on a fiduciary, in addition to any liability which it may have under any other provision, for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it knows of a breach and fails to remedy it, knowingly participates in a breach, or enables a breach. The Defendants breached all three provisions.

165. **Knowledge of a Breach and Failure to Remedy.** ERISA § 405(a)(3), 29 U.S.C. § 1105(a)(3), imposes co-fiduciary liability on a fiduciary for a fiduciary breach by another fiduciary if it has knowledge of a breach by such other fiduciary, unless it makes reasonable efforts under the circumstances to remedy the breach. Upon information and belief, each Defendant knew of the breaches by the other fiduciaries and made no efforts, much less reasonable ones, to remedy those breaches.

166. **Knowing Participation in a Breach.** ERISA § 405(a)(1), 29 U.S.C. § 1105(a)(1), imposes liability on a fiduciary for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach. Upon information and belief, each Defendant participated in the breaches by the other fiduciaries.

167. **Enabling a Breach.** ERISA § 405(a)(2), 29 U.S.C. § 1105(a)(2), imposes liability on a fiduciary if, by failing to comply with ERISA § 404(a)(1), 29 U.S.C.

§1104(a)(1), in the administration of its specific responsibilities which give rise to its status as a fiduciary, it has enabled another fiduciary to commit a breach. Upon information and belief, each Defendant enabled the breaches by the other fiduciaries.

168. Plaintiffs Mohr and Sohmer and the ERISA Subclass have been damaged in the amount of the Spread compensation Defendants took.

169. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to: "(A) [ ] enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

170. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiffs Mohr and Sohmer and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) full disclosure of the foregoing acts and practices; or

(h) any other remedy the Court deems proper.

COUNT VII

For Breach of Contract on Behalf of the Non-ERISA Subclass

171. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

172. Defendants offered and sold health insurance policies in all fifty states, including Minnesota, during the class period alleged herein.

173. The policies constitute contracts under the laws of each of the states in which they were sold, and in all material respects for this action, the policies are uniform contracts.

174. The definitions of the terms used in Non-ERISA Subclass members' policies are materially the same, including, but not limited to, the definitions of the policy terms such as: "Allowed Amount," "Deductible," "Benefits," "Co-payment," "Co-insurance," "Covered Health Services," "Eligible Expenses," "Pharmaceutical Product(s)," "Premium," "Prescription Drug Charge," Prescription Drug Product," and "Usual and Customary Charge."

175. Plaintiff Wiltsie and all Non-ERISA Subclass members purchased the policies that Defendants offered and sold and are either parties to or third-party beneficiaries of such health insurance policies.

176. Defendants breached the policies in each of the fifty states by requiring its insureds to pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

177. Plaintiff Wiltsie and all Non-ERISA Subclass members have suffered damages as result of Defendants' breaches.

178. Plaintiff Wiltsie and the Non-ERISA Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT VIII

For Breach of Contract
on Behalf of the Michigan Subclass

179. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

180. Defendants offered and sold health insurance policies in Michigan during the class period alleged herein.

181. The policies constitute contracts under Michigan law and, in all material respects for this action, the policies are uniform contracts.

182. The definitions of the relevant terms used in Subclass members' policies are materially the same, including, but not limited to, the definitions of the policy terms such as: "Allowed Amount," "Deductible," "Benefits," "Co-payment," "Co-insurance," "Covered Health Services," "Eligible Expenses," "Pharmaceutical Product(s)," "Premium," "Prescription Drug Charge," Prescription Drug Product," and "Usual and Customary Charge."

183. Plaintiff Wiltsie and all members of the Michigan Subclass purchased the policies that Defendants offered and sold and are either parties to or third-party beneficiaries of such health insurance policies.

184. Defendants breached the policies in Michigan by requiring its insureds to pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

185. Plaintiff Wiltsie, and members of the Michigan Subclass, have suffered damages as result of Defendants' breaches.

186. Plaintiff Wiltsie and the Michigan Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT IX

For Breach of Covenant of Good Faith and Fair Dealing on Behalf of the Non-ERISA Subclass

187. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

188. All contracts contain an implied covenant of good faith and fair dealing, including Plaintiff Wiltsie's and Non-ERISA Subclass members' contracts with Defendants.

189. Plaintiff Wiltsie and all Non-ERISA Subclass members purchased the policies that Defendants offered and sold and are either parties to or third-party beneficiaries of such health insurance policies including the covenant of good faith and fair dealing implied in such policies.

190. As alleged herein, Defendants caused its insureds to pay excessive fees for prescription drugs that were and are not reasonably permitted under the policies.

191. Defendants' performance under the policies deprived Plaintiff Wiltsie and other Non-ERISA Subclass members of the prescription drug benefits that a reasonable consumer would expect to receive under the policies.

192. On information and belief, Defendants' actions as alleged herein were performed in bad faith, in that the purpose behind the practices and policies alleged herein was to maximize Defendants' and/or their agents' revenue at the expense of Plaintiff Wiltsie and the Non-ERISA Subclass members in contravention of the reasonable expectations of Plaintiff Wiltsie and the Non-ERISA Subclass members.

193. Defendants have breached the covenant of good faith and fair dealing in policies as alleged herein.

194. Plaintiff Wiltsie and members of the putative Non-ERISA Subclass have sustained damages as a result of Defendants' breaches as alleged herein.

195. Plaintiff Wiltsie and the Non-ERISA Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT X

For Breach of Covenant of Good Faith and Fair Dealing on Behalf of the Michigan Subclass

196. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

197. Under Michigan law, all contracts contain an implied covenant of good faith and fair dealing, including Plaintiff Wiltsie's and Michigan Subclass members' contracts with Defendants.

198. Plaintiff Wiltsie and all Michigan Subclass members purchased the policies that Defendants offered and sold and are either parties to or third-party beneficiaries of such health insurance policies including the covenant of good faith and fair dealing implied in such policies.

199. As alleged herein, Defendants caused its insureds to pay excessive fees for prescription drugs that were and are not reasonably permitted under the policies.

200. Defendants' performance under the policies deprived Plaintiff Wiltsie and other Michigan Subclass members of the prescription drug benefits that a reasonable consumer would expect to receive under the policies.

201. On information and belief, Defendants' actions as alleged herein were performed in bad faith, in that the purpose behind the practices and policies alleged herein was to maximize Defendants' and/or its agents' revenue at the expense of Plaintiff Wiltsie and the Michigan Subclass members in contravention of the reasonable expectations of Plaintiff and the Michigan Subclass members.

202. Defendants have breached the covenant of good faith and fair dealing in policies as alleged herein.

203. Plaintiff Wiltsie and members of the putative Michigan Subclass have sustained damages as a result of Defendants' breaches as alleged herein.

204. Plaintiff Wiltsie and the Michigan Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT XI

For Unfair and Deceptive Trade Practices on Behalf of the Non-ERISA Subclass

205. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

206. Defendants are engaged in "trade" and "commerce" as they offer insurance for sale to consumers.

207. Defendants' conduct as alleged above constitutes unfair and/or deceptive practices in at least the following ways:

(a) Defendants' policies materially misrepresent and mislead reasonable consumers as to the fees that they would pay for prescription drugs;

(b) Defendants' acts and practices result in reasonable consumers paying impermissible and excessive prescription drug fees;

(c) Defendants' conduct is directed toward and is substantially injurious to consumers; no benefit to consumers or competition results from Defendants' conduct, nor could consumers reasonably have avoided the injury that Defendants caused, in large part because Defendants require or cause its subsidiaries, agents and other participants in the unlawful acts to maintain the secrecy of those acts and their pernicious effects;

208. The foregoing unfair and/or deceptive practices directly, foreseeably and proximately caused Plaintiff Wiltsie and the Non-ERISA Subclass to suffer substantial injuries when they paid impermissible and excessive prescription drug fees.

209. The foregoing actions constitute unfair and deceptive practices in violation of state statutes that prohibit unfair and/or deceptive trade practices.

210. Plaintiff Wiltsie and the Non-ERISA Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT XII

For Violating Michigan's Consumer Protection Act, § MCL 445.901, *et seq*. on Behalf of the Michigan Subclass

211. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

212. Defendants engaged in unfair or deceptive methods, acts, or practices in the conduct of trade or commerce in that they:

(a) Represented that goods or services have characteristics, benefits, or quantities that they do not have;

(b) Represented that goods or services are of a particular standard, quality, or grade;

(c) Caused a probability of confusion or of misunderstanding as to the legal rights, obligations, or remedies of a party to a transaction;

(d) Failed to reveal a material fact, the omission of which tends to mislead or deceive the consumer, and which fact could not reasonably be known by the consumer;

(e) Charged the consumer a price that is grossly in excess of the price at which similar property or services are sold;

(f) Made a representation of fact or statement of fact material to the transaction such that a person reasonably believes the represented or suggested state of affairs to be other than it actually is; and/or

(g) Failed to reveal facts that are material to the transaction in light of representations of fact made in a positive manner.

213. The foregoing actions constitute unfair and deceptive practices in violation of Michigan's Consumer Protection Act, § 445.901, *et seq*., prohibiting unfair and/or deceptive trade practices.

214. Plaintiff Wiltsie and the Michigan Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT XIII

For Violating Chapter 20 of Michigan's Insurance Code of 1956, § MCL 500.2001, *et seq*. on Behalf of the Michigan Subclass

215. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

216. Defendants engaged in unfair and prohibited trade practices in that they misrepresented the terms, benefits, advantages, or conditions of an insurance policy.

217. The foregoing actions constitute unfair and deceptive practices in violation of Chapter 20 of Michigan's Insurance Code of 1956, § 500.2001, *et seq*., prohibiting unfair trade practices.

218. Plaintiff Wiltsie and the Michigan Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT XIV

For Unjust Enrichment on Behalf of the Non-ERISA Subclass

219. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

220. To the detriment of Plaintiff Wiltsie and members of the Non-ERISA Subclass, Defendants have been, and continue to be, unjustly enriched by requiring their insureds to pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

221. Defendants have unjustly benefited through the unlawful and/or wrongful collection of deductibles, co-payments, and/or co-insurance payments that are based on fees that exceed the actual fees that Defendants or their agents paid to pharmacies for prescription drugs.

222. The amount of unjust enrichment is the difference between the fees paid for prescription drugs by the insured and fees actually paid by Defendants or their agents to the pharmacy for the prescription drugs.

223. Accordingly, Plaintiff Wiltsie and members of the Non-ERISA Subclass seek full restitution of Defendants' enrichment, benefits and ill-gotten gains acquired as a result of the unlawful and/or wrongful conduct alleged herein.

COUNT XV

For Unjust Enrichment on Behalf of the Michigan Subclass

224. Plaintiff Wiltsie incorporates by reference each and every allegation above as if set forth fully herein.

225. To the detriment of Plaintiff Wiltsie and members of the Michigan Subclass, Defendants have been, and continue to be, unjustly enriched by requiring its insureds to pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

226. Defendants have unjustly benefited through the unlawful and/or wrongful collection of deductibles, co-payments, and/or co-insurance payments that are based on fees that exceed the actual fees that Defendants or their agents paid to pharmacies for prescription drugs.

227. Defendants received a benefit from Plaintiff Wiltsie and the Michigan Subclass and an inequity results to Plaintiff Wiltsie and the Michigan Subclass because of the retention of the benefit by the Defendants.

228. The amount of unjust enrichment is the difference between the fees paid for prescription drugs by the insured and fees actually paid by Defendants or their agents to the pharmacy for the prescription drugs.

229. Accordingly, Plaintiff Wiltsie and members of the Michigan Subclass seek full restitution of Defendants' enrichment, benefits and ill-gotten gains acquired as a result of the unlawful and/or wrongful conduct alleged herein.

COUNT XVI

For Violating RICO, 18 U.S.C. § 1962(c) on Behalf of the Nationwide Class

230. Plaintiffs incorporate by reference each and every allegation above as if set forth fully herein.

231. For the purposes of this Count, and pursuant to Fed. R. Civ. P 8(d), the Enterprise is alternatively Optum and/or each pharmacy that participates in the provider network that Optum manages.

232. At all relevant times, each Defendant is and was engaged in interstate commerce or its activities affected interstate commerce and is and was a culpable person that has been associated with the Enterprise.

233. Optum — one of the largest PBMs in the United States — and all of the pharmacies in the provider network that it manages ("Participating Pharmacies") also are engaged in interstate commerce or in activities that affect interstate commerce.

234. Defendants' scheme to defraud was and is facilitated by the fact that Optum and the Participating Pharmacies are separate legal and distinct entities from Defendants. The scheme relies on the separateness of the health insurer and the PBM and Participating Pharmacies and could not be orchestrated effectively without this legal separateness. As alleged herein, the scheme to defraud Plaintiffs and Class members was accomplished pursuant to the various contracts between the health insurer and the policy holder, on the one hand, and the PBM and the Participating Pharmacies, on the other hand. Additionally, the scheme to defraud Plaintiffs and Class members was facilitated by Optum's

relationship as a PBM with a network of Participating Pharmacies throughout the country from which Plaintiffs and Class members obtained prescription drugs pursuant to their health insurance policies.

235. While associated with the Enterprise, each Defendant conducts or participates, directly or indirectly, in the conduct of the Enterprise's affairs through a pattern of racketeering activity. As alleged herein, Optum is a wholly-owned subsidiary of UnitedHealth Group and as such is controlled and managed by UnitedHealth Group. For example, Larry Renfro, Vice-Chairman of UnitedHealth Group is the Chief Executive Officer of Optum; Simon Stevens, the EVP and President of UnitedHealth Group – Global Health is a board member of Optum; and Stephen Helmsley, the CEO of UnitedHealth Group is also a senior executive with OptumHealth, Inc. Through its wholly-owned but separate subsidiary, Optum, Defendants have facilitated and/or authorized relationships with Participating Pharmacies that enable the pattern of racketeering activity.

236. Defendants have directly and indirectly conducted and participated in the conduct of the Enterprise's affairs through an on-going, continuous and related pattern of racketeering activity that was and is the Enterprise's regular way of conducting its business and/or that distinctly threatens continued criminally indictable activity.

237. As described more fully below, pursuant to and in furtherance of their fraudulent scheme, Defendants have committed multiple, related predicate acts within the relevant time period and within the last ten years that are indictable as mail and/or wire fraud pursuant to 18 U.S.C. §§ 1341 and 1343. The predicate acts had a common purpose and similar results on similar victims.

238. As alleged herein, the plan or scheme to defraud entails: (a) Defendants representing to Plaintiffs and Class members through form insurance policy language that they would pay a certain amount for prescription drugs; (b) Defendants entering into agreements with Optum, and Optum, in turn, entering into agreements with Participating Pharmacies, instructing the Participating Pharmacies to overcharge Plaintiffs and Class members for prescription drugs; (c) Plaintiffs and Class members in fact being overcharged for prescription drugs; and (d) agreements between Optum and Participating Pharmacies prohibiting the disclosure of the unlawful scheme and/or the sale of prescription drugs to Plaintiffs and Class members at prices other than the unlawful prices. As such, the plan was to deprive Plaintiffs and Class members of money by deceit and false pretenses, and it was characterized by a departure from community standards of fair play and candid dealings.

239. The scheme to defraud includes various misrepresentations and omissions of material fact, including, but not limited to: (a) the representation in the plain form language of the policy that Class members would pay a certain amount for prescriptions drugs with knowledge and intent that Class members would be charged a higher amount; (b) the failure to disclose that a material portion of the "co-payments" were neither payments for prescription drugs nor were they "co-" payments by the insureds in conjunction with a payment by the insurer for the prescription drugs, as required by the plain language of the policies, but rather were unlawful payments to Defendants and/or their PBM; (c) the failure to disclose that prescription drug payments under deductible portions of health insurance policies were based on prescription drug prices that exceeded the contracted fee between

the PBM and the Participating Pharmacies, as required by the plain form language of the policy; (d) the failure to disclose that co-insurance payments were based on prescription drug prices that exceeded the contracted fee between the PBM and the Participating Pharmacies, as required by the plain form language of the policy; and (e) the failure to disclose and agreement not to disclose that Class members could pay less for a drug by purchasing it outside of their respective insurance policies.

240. The scheme to defraud consists of Defendants' wrongly depriving Plaintiffs and Class members in their property rights by dishonest methods or schemes. Such scheme was willfully devised by Defendants, with each being a knowing and active participant in the scheme to defraud. Each Defendant specifically intended to commit fraud, and such intent can be inferred from the totality of the allegations herein. Indeed, Defendants' nefarious intent and brazen, on-going unlawful conduct is evidenced by UHC Services' prior entry into the Stipulation of Settlement in Minnesota federal court in 2004 discussed above, in which it agreed to an injunction that, in sum and substance, prohibited it from engaging in some of the same unlawful consumer-gouging conduct alleged herein.

241. The purpose of the scheme was and is to cause Plaintiffs and Class members to overpay for their prescription drugs so that the overcharge would be clawed back by Optum and then incorporated into UnitedHealth Group's financials.

242. It was and is reasonably foreseeable by Defendants that mail, interstate carriers and wire transmissions would be used — and mail, interstate carriers and wire transmissions were in fact used — in furtherance of the scheme, including but not limited to the following manner and means: (a) Defendants' send and receive papers via mail,

interstate carriers and/or wire transmissions in connection with the scheme to defraud, including, but not limited to, insurance policies, applications, agreements, Policy Summaries and miscellaneous health insurance documentation; (b) whenever a prescription was or is filled, information is entered into a computer and transmitted via interstate mail or carrier and/or wire transmissions for adjudication; (c) the clawing back of money did and does take place via interstate mail or carrier or wire transmissions; (d) Class members made and make payments at pharmacies using credit or debit cards, which require the use of use of interstate wire transmissions; (e) the payment of premiums were made to Defendants via interstate mail or carrier and/or wire transmissions (f) prescription drugs purchased through the fraudulent scheme were delivered by mail or interstate carrier and (g) representatives of Defendants and their PBM communicated with each other by mail, interstate carrier and or wire transmissions in order to carry out the fraudulent scheme.

243. On or about the dates set forth below, Defendants unlawfully, willfully, and knowingly, having devised and intending to devise a scheme and artifice to defraud by obtaining money and property by means of false and fraudulent pretenses, representations, and promises, transmitted and caused to be transmitted by means of wire communication in interstate commerce, writings, signs, signals, pictures, and sounds, for the purpose of executing such scheme and artifice.

244. For example, when Plaintiff Mohr purchased prescription drugs, Defendants caused to be transmitted mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on at least the following dates: July 18,

2011; September 12, 2011; October 24, 2011; November 15, 2011; November 28, 2011; December 31, 2011; January 31, 2012; March 3, 2012; April 7, 2012, May 3, 2012; June 1, 2012; June 15, 2012; July 5, 2012; August 3, 2012; September 5, 2012; October 27, 2012; November 14, 2012; December 1, 2012; December 22, 2012; December 24, 2012; January 14, 2013; January 22, 2012; January 1, 2013; March 4, 2013; March 16, 2013; March 29, 2013; April 3, 2013; April 8, 2013; April 25, 2013; May 18, 2013; June 15, 2013; July 13, 2013; September 9, 2013; October 9, 2013; November 9, 2013; December 5, 2013; December 14, 2013; January 11, 2014; January 18, 2014; February 11, 2014; March 5, 2014; April 15, 2014; April 30, 2014; May 13, 2014; June 7, 2014; June 25, 2014; July 28, 2014; August 25, 2014; October 6, 2014; December 1, 2014; January 8, 2015; February 3, 2015; March 16, 2015; April 16, 2015; April 20, 2015; May 6, 2015; May 23, 2015; July 2, 2015; August 10, 2015; September 1, 2015; September 8, 2015; October 2, 2015; October 30, 2015; March 10, 2016; April 12, 2016; June 7, 2016; July 26, 2016; and August 31, 2016.

245. Additionally, when Plaintiff Sohmer purchased prescription drugs, Defendants caused to be transmitted mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on at least the following dates: October 7, 2014; December 1, 2014; March 23, 2015; July 18, 2015; and February 10, 2016.

246. Further, when Plaintiff Wiltsie purchased prescriptions drugs, Defendants caused to be transmitted mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on at least the following dates: March 10,

2015; June 1, 2015; September 11, 2015; October 14, 2015; November 9, 2015; December 9, 2015; January 6, 2016; March 5, 2016; March 31, 2016; April 27, 2016; May 25, 2016; June 24, 2016; July 15, 2016; August 25, 2016; and September 20, 2016.

247. On or about these dates, BJs Drugs (for Plaintiff Mohr), located in Forest Hills, New York, ShopRite Pharmacy (for Plaintiff Sohmer), located in Parsippany, New Jersey, and Par Wick Pharmacy (for Plaintiff Wiltsie), located in Taylor, Michigan, sent and received mail, interstate messages or deliveries and/or wire transmissions in connection with (a) determining whether the Plaintiffs and the prescription drugs were covered under their health insurance policies and how much Plaintiffs should pay for the drugs; (b) processing Plaintiffs' payments for such prescription drugs; and (c) processing the PBM's payments to and/or Clawback from the pharmacies.

248. As a direct and proximate result of Defendants' racketeering activities and violations of 18 U.S.C. § 1962(c), Plaintiffs and the Class have been injured in their property in that they paid excessive and fraudulent fees for prescription drugs.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, individually and on behalf of the Class and Subclasses, pray for relief as follows as applicable for the particular claim:

A. Certifying this action as a class action and appointing Plaintiffs and the counsel listed below to represent the Class and respective Subclasses;

B. Finding that Defendants violated their fiduciary duties to ERISA members and awarding Plaintiffs Mohr and Sohmer and the ERISA Subclass such relief as the Court deems proper;

C. Finding that Defendants engaged in prohibited transactions and awarding Plaintiffs Mohr and Sohmer and the ERISA Subclass such relief as the Court deems proper;

D. Finding that Defendants denied Plaintiffs and the Class benefits and their rights under the policies and awarding such relief as the Court deems proper;

E. Finding that Plaintiffs and the Class are entitled to clarification of the rights under the policies and awarding such relief as the Court deems proper;

F. Awarding Plaintiffs and the Class damages as deemed appropriate by the Court;

G. Awarding treble damages in favor of Plaintiffs and the other Nationwide Class members against all Defendants for all damages sustained as a result of Defendants' violation of RICO, in an amount to be proven at trial, including interest thereon;

H. Awarding Plaintiffs and the Class equitable relief to the extent permitted by the above claims;

I. Finding that Defendants are jointly and severally liable as fiduciaries and/or co-fiduciaries and/or parties in interest;

J. Awarding Plaintiffs' counsel attorneys' fees, litigation expenses, expert witness fees and other costs pursuant to ERISA § 502(g)(1), 29 U.S.C. 1132(g)(1), and/or the common fund doctrine;

K. Awarding Plaintiffs and the Classes their reasonable costs and expenses incurred in this action, including counsel fees and expert fees; and

L. Awarding such other and further relief as may be just and proper, including pre-judgment and post-judgment interest on the above amounts.

JURY TRIAL DEMANDED

Plaintiffs hereby demand a trial by jury.

Dated: October 4, 2016

Respectfully submitted,

s/ Daniel R. Shulman

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