UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE AMERICAN MEDICAL ASSOCIATION, et al., Plaintiffs, v. UNITED HEALTHCARE CORPORATION, et al., Defendants.	Master File No. 00 Civ. 2800 (LMM) (GWG) **CLASS ACTION** **FOURTH AMENDED COMPLAINT** **Demand for Jury Trial on All Claims So Triable**

INTRODUCTION

1. For their Fourth Amended Complaint, Plaintiffs assert claims sounding in the Employment Retirement Income Security Act ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO"), the Sherman Antitrust Act, Florida RICO, and New York contract and deceptive practices law.

2. Plaintiffs bring this action pursuant to health care plans directly insured and/or administered by United Healthcare Corporation or one of its wholly owned and controlled subsidiaries, including United Healthcare Service Corporation, United Health Group Incorporated, United HealthCare Insurance Company, United Healthcare Insurance Company of New York, United Healthcare of the Midwest, Inc., United Healthcare Services of Minnesota, Inc., and Ingenix, Inc. (collectively referred to herein as "United Healthcare"). The plans at issue, referred to herein as "Choice" plans, permit subscribers to obtain health care services from physicians who have not entered into contracts with United Healthcare (referred to as "out-of-network" or "non-participating" providers). United Healthcare is required under the terms of its health care contracts to pay benefits for such out-of-network services based on the lower of the

actual billed charge and the usual, customary and reasonable ("UCR") rate for that service. United Healthcare breached its ERISA-governed plan language and non-ERISA contracts by using flawed or inadequate data to determine UCR amounts, which results in reimbursements well below actual UCR for such out-of-network medical services. United Healthcare's wholly owned subsidiary, Ingenix, owns the two databases relied on by United Healthcare and most commercial insurers nationwide to make such UCR determinations (the "Ingenix databases").

3. Subscriber Plaintiffs David and Colleen Finley, S. Joseph Domina, Sandra Taylor, Clifford Wilson (individually and as executor for his wife, Michele), Peter Oborski, Michael and Susie Grisham, Paul Steinberg, Helene Coull, and Edward Mitchell allege that United Healthcare breached its fiduciary duties under ERISA, for which they seek equitable and declaratory relief. Subscriber Plaintiffs David and Colleen Finley seek unpaid benefits from United Healthcare (excluding Ingenix) for those reduced UCR payments for which they exhausted administrative remedies. The Finleys also seek relief under Florida RICO. Subscriber Plaintiffs Wilson and Oborski seek unpaid benefits against defendant American Airlines ("AA") for those reduced UCR payments for which they exhausted administrative remedies. Plaintiffs seek the full extent of their health benefits to which they are entitled, and other appropriate equitable and legal relief. All plaintiffs assert claims under RICO and the Sherman Antitrust Act based on the manner in which United Healthcare promotes and uses its Ingenix databases.

JURISDICTION AND VENUE

ERISA and Breach of Contract Claims

4. Subscriber Plaintiffs' ERISA claims arise under § 29 U.S.C. § 1132 of ERISA and under 28 U.S.C. § 1331 (federal question jurisdiction). The breach of contract and New York General Business Law § 349 claims asserted by the Empire Plan Plaintiffs and the New

York Union Plaintiffs arise under New York law over which the Court has exercised supplemental jurisdiction under 28 U.S.C. § 1367.

5. Venue is appropriately established in this Court under 28 U.S.C. § 1391 because Defendants United Healthcare and American Airlines, Inc. ("American Airlines") conduct a substantial amount of business in this district and a substantial part of the events or omissions giving rise to the claims occurred in this district. In addition, Defendant Metropolitan Life Insurance Co. ("Met Life") has its principal place of business in New York.

Antitrust Claims

6. Plaintiffs who are individuals (Subscribers and medical providers, the "Individual Plaintiffs") are permitted as private parties to institute actions seeking damages under the Sherman Act pursuant to 15 U.S.C. § 15 ("[a] person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefore in any district court of the United States . . . and shall recover threefold the damages by him sustained").

7. All Plaintiffs (including the Medical Associations and the New York Union Plaintiffs (defined below) are entitled to sue for and obtain injunctive relief under 15 U.S.C. § 26 ("[a] person . . . shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws").

8. This Court has subject matter jurisdiction over these counts under the Sherman Act and Clayton Act pursuant to 28 U.S.C. § 1337.

RICO Claims

9. This Court has subject matter jurisdiction over the federal RICO claims, arising under the laws of the United States, pursuant to 28 U.S.C. § 1331. All Plaintiffs are entitled to sue for relief for United Healthcare's violation of federal RICO. Individual Plaintiffs seek

monetary damages (including treble damages) and injunctive and equitable relief. The Medical Association Plaintiffs and the New York Union Plaintiffs seek injunctive and declaratory relief.

10. Plaintiffs David and Colleen Finley (the "Finleys"), residents of Lake City, Florida, also seek relief for United Healthcare's violations of the Florida RICO Act. The Finleys assert claims to enjoin United Healthcare from continuing to engage in such unlawful conduct in the State of Florida and seek injunctive relief for themselves and a Florida RICO Subclass defined herein.

11. This Court has subject matter jurisdiction over the Finleys' claims under the Florida RICO Act pursuant to the Court's supplemental jurisdiction, 28 U.S.C. §1367.

12. Venue is proper in this judicial district pursuant to 28 U.S.C. § 1391(b) and 18 U.S.C. § 1965(a) because (a) United Healthcare resides, is found, has an agent, and transacts its affairs in this district; (b) United Healthcare conducts a substantial amount of business in this district and insures and administers group health plans both inside and outside this State, including from offices in this state; and (c) a substantial part of the events giving rise to the claims brought against United Healthcare occurred in this district. Similarly, venue is proper in this judicial district with respect to defendant MetLife because it resides and is headquartered and transacts business here and with respect to defendant American Airlines because it conducts a substantial amount of business in this district.

THE PARTIES

Plaintiffs

A. Direct Insured Plaintiffs

13. Plaintiffs David and Colleen Finley reside in Florida. United Healthcare was the direct insurer of the Finleys' group health Choice plan, which permitted the Finleys to obtain health care services from out-of-network providers and to be reimbursed for UCR rates. As

subscribers to a direct insured plan, the Finleys ("Direct Insured Plaintiffs") were reimbursed for their insured medical expenses directly by United Healthcare. In addition, United Healthcare functions as the "plan administrator" for the Finleys' health plan, as that term is defined under ERISA. The Finleys assert class claims under ERISA, RICO, Florida RICO, and the Sherman Act. The Finleys seek unpaid benefits for all of their exhausted claims against United Healthcare (excluding Ingenix). They seek equitable and declaratory relief against United Healthcare (including Ingenix) for its breach of fiduciary duties under ERISA.

B. Self-Funded Plaintiffs

14. Plaintiff S. Joseph Domina resides in New York, and is retired from Chase Manhattan Bank. Chase Manhattan Bank operates and administers a self-funded Choice health plan which has contracted with United Healthcare to administer claims for its subscribers.

15. Plaintiff Clifford E. Wilson, who resides in Pennsylvania (and who brings an action on his own behalf and as the executor of the estate of his wife, Michele S. Wilson, who died on June 1, 2001, after the commencement of this action); Peter Oborski, who resides in Connecticut; Sandra Taylor, who resides in Wisconsin; Michael and Susie Grisham, who reside in California; Helene Coull, who also resides in California; and Paul Steinberg, who resides in Nevada, are all current or former employees (or the spouse of such an employee) of American Airlines (collectively, the "American Airlines Plaintiffs"). American Airlines operates and administers a self-funded Choice health plan that has contracted with United Healthcare to administer claims for its subscribers.

16. Plaintiff Edward Mitchell, Jr. resides in New York, and is retired from Osram Sylvania. Osram Sylvania operated and administered a self-funded Choice benefit plan which, during the relevant period, contracted with United Healthcare to administer claims for its subscribers.

17. Self-funded Plaintiffs are all ERISA subscribers who seek relief for United Healthcare's breach of fiduciary duties under ERISA. In addition, Self-Funded Plaintiffs assert claims under RICO and the Sherman Act against United Healthcare. The American Airlines Plaintiffs further seek monetary and equitable relief under ERISA against American Airlines.

18. Direct Insured Plaintiffs and Self-Funded Plaintiffs are collectively referred to as Subscriber Plaintiffs.

C. Empire Plan Plaintiffs

19. Plaintiffs Senator Toby Ann Stavisky, Cynthia Falk, Mary Gilmartin, Janet Stravitz, Gail Temple, Thomas Lawrence and Joan Lawrence reside in New York (the "Empire Plan Plaintiffs"). They subscribe to a health plan offered to many New York State and municipal employees, including firefighters, police, and teachers (called the Empire Health Plan.), which is directly insured and administered by United Healthcare, and was formerly directly insured and administered by Met Life. They assert claims under New York law for breach of contract and for violation of New York's General Business Law § 349. This Court has exercised supplemental jurisdiction over these claims. These plaintiffs also assert claims under RICO and the Sherman Act.

D. Physician Plaintiffs

20. Plaintiff Dr. Michael J. Attkiss resides in New York and Dr. William B. Ericson resides in Washington. They are members of the American Medical Association and of their respective state medical societies. These Plaintiffs (the "Physician Plaintiffs") have obtained assignments from subscribers to ERISA plans that are directly insured by United Healthcare, and for which United Healthcare functions as the plan administrator. The Physician Plaintiffs assert claims under ERISA for unpaid benefits for assigned claims that have been exhausted. The Physician Plaintiffs also assert claims for breach of fiduciary duty against United Healthcare

under ERISA. In addition, the Physician Plaintiffs assert claims under RICO and the Sherman Act against United Healthcare.

E. Medical Association Plaintiffs

21. Plaintiff American Medical Association ("AMA") is headquartered in Chicago, Illinois. The AMA is a national tax-exempt membership organization that represents the interests of approximately 240,000 physicians, residents and medical students, as well as their patients located in New York and throughout the United States. As the largest medical association in the United States and as the owner of Current Procedural Terminology ("CPT"), the AMA works to represent its members with respect to payment practices by third party payors, such as Defendants, to health care providers, particularly physicians.

22. The Medical Society of the State of New York ("MSSNY") is a non-profit membership organization representing the interests of physicians and their patients in New York, such as Plaintiff Dr. Attkiss, and has approximately 28,000 member physicians, medical residents and medical students. The MSSNY, which is headquartered in Lake Success, New York, is committed to representing the medical profession in advocating health-related rights, responsibilities and issues.

23. Plaintiff The Missouri State Medical Association ("MSMA") is a not-for-profit membership organization headquartered in Jefferson City, Missouri, which represents the interests of physicians and their patients in Missouri. MSMA's membership includes approximately 5,500 licensed physicians, medical residents and medical students in Missouri.

24. The AMA, MSSNY and MSMA, collectively referred to herein as the Medical Association Plaintiffs, appear herein on behalf of themselves and their members, and also as representatives of the Litigation Center of the AMA and the State Medical Societies. The

Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

25. The Medical Association Plaintiffs bring this action on behalf of their members who have claims against United Healthcare for medical treatment they performed as out-of-network providers for policyholders whose health plans are directly insured by United Healthcare. They seek declaratory and injunctive relief for United Healthcare's violations under RICO and the Sherman Act.

F. New York Union Plaintiffs

26. New York State United Teachers ("NYSUT"), which maintains its principal place of business at 800 Troy-Schenectady Road, Latham, New York 12110, is a statewide union representing approximately 580,000 classroom teachers and other school employees, academic and professional faculty at the state's community colleges, the State University of New York and the City University of New York, and other education and health professionals. NYSUT has 1,050 affiliated local unions throughout New York, and is affiliated with the American Federation of Teachers, AFL-CIO. About 100,000 NYSUT members are eligible to be enrolled in the Empire Plan, as state employees or local municipal or school district employees, a substantial portion of whom have elected to become Empire Plan subscribers.

27. Civil Service Employees Association ("CSEA"), which maintains its principal place of business at 143 Washington Avenue, Albany, New York, is a union representing approximately 265,000 employees of New York State. CSEA is an affiliate of AFSCME, AFL-CIO. Of its total membership, a significant percentage are Empire Plan subscribers.

28. The Organization of New York State Management/Confidential Employees ("OMCE"), which maintains its principal place of business at 10 Russell Road, Albany, New York 12206-1334, is a union representing approximately 2,200 Management/ Confidential

employees of New York State. OMCE is an affiliate of OPEIU Local 153, AFL-CIO. Of its total membership, approximately 70%, or 1,500, are Empire Plan subscribers.

29. New York State Police Investigators Association ("NYSPIA"), which is headquartered at 507 Weatheridge Drive, Camillus, New York 13031, is a public employee union affiliated with the International Union of Police Associations (IUPA), AFL-CIO. NYSPIA has approximately 950 active union members, all of whom are sworn members of the New York State Police. As the certified representative of the unit consisting of investigators, senior investigators and investigative specialists assigned to the Bureau of Criminal Investigation of the Division of the State Police, NYSPIA negotiates collectively with their employer, the State of New York, in regard to terms and conditions of employment, including health insurance benefits. Of NYSPIA's members, approximately 85%, or more than 800, are Empire Plan subscribers.

30. NYSUT, CSEA, OMCE and NYSPIA, referred to herein as the New York Union Plaintiffs, bring this action on behalf of their members who were participants or subscribers of the Empire Plan with claims against United Healthcare or Met Life for medical treatment they received from out-of-network providers and who have been, or will be, harmed by United Healthcare's actions as alleged herein. They seek declaratory and injunctive relief for United Healthcare's violations under New York state law for breach of contract and violation of New York's General Business Law § 349, RICO and the Sherman Act.

Defendants

31. Defendant United HealthCare Corporation, also known as United Health Group Incorporated, is an insurance company incorporated in Delaware with its principal place of business in Minnetonka, Minnesota. Defendant United Healthcare Service Corporation is located in Kingston, New York and is the plan administrator for the Empire Plan. Defendant United HealthCare Insurance Company is a wholly owned and controlled subsidiary of United

HealthCare Corporation. Defendant United HealthCare Services of Minnesota, Inc. is the plan administrator for the Finleys' group health plan. Defendant United HealthCare Insurance Company is the insurer of the Finleys' group health policy, and is principally located in New Haven, Connecticut. Defendant United Healthcare Insurance Company of New York is a wholly owned and controlled subsidiary of United HealthCare Corporation, which maintains its principal place of business in New York, and has made UCR determinations for certain Plaintiffs. Defendant United Healthcare of the Midwest, Inc. is a wholly owned and controlled subsidiary of United HealthCare Corporation, and it made UCR determinations for certain Plaintiffs. Defendant Ingenix, Inc., a wholly owned and controlled subsidiary of United HealthCare Corporation, acquired Medicode, Inc., and its MDR database, on or about December 1997, and acquired the Prevailing Healthcare Charges System database ("PHCS") from the Health Insurance Association of America ("HIAA"), an industry trade group, on or about October of 1998. Collectively, MDR and PHCS are referred to herein as the "Ingenix Databases." Ingenix currently develops and sells the Ingenix Databases to other insurers for use in making UCR determinations.

32. Defendant Met Life has its principal place of business in New York and at times material to this litigation administered the Empire Plan on behalf of New York State and municipal public employees. Met Life is identified as the "insurer" of the Empire Plan.

33. American Airlines operates a national airline that has its principal place of business in Dallas, Texas. American Airlines is the plan administrator for the group health plan offered to the American Airlines Plaintiffs.

SUMMARY OF ALLEGATIONS CONCERNING UCR POLICIES

Overview

34. United Healthcare directly insures many group health plans. When United Healthcare insures such group health plans, it functions as the "plan administrator" as that term is defined under ERISA, and thus assumes all obligations imposed by ERISA on such plan administrators. United Healthcare is the direct insurer of Plaintiffs David and Colleen Finley.

35. United Healthcare also functions as a fiduciary for self-funded health plans, including those of the Self-Funded Plaintiffs, and is obligated to comply with ERISA's fiduciary duties. United Healthcare exercises discretionary authority and control in its interactions with self-funded health plans and their subscribers.

36. By making UCR determinations without valid or appropriate data to support reduced payments, United Healthcare violated its fiduciary obligations under ERISA as well as disclosure and other statutory obligations.

37. When United Healthcare insures a plan directly, as well as when it exercises discretionary authority or control, United Healthcare is an ERISA fiduciary. United Healthcare therefore owes fiduciary duties to all subscribers in its ERISA plans.

38. As the plan administrator for the American Airlines Plaintiffs' group health plan, American Airlines is an ERISA fiduciary and must comply with ERISA fiduciary duties. American Airlines Plaintiffs assert claims alleging that American Airlines violated its fiduciary duties under ERISA.

The Ingenix Databases and Their Pervasive Flaws

39. In December 1997, Defendant Ingenix purchased Medicode, Inc., a Salt Lake City-based provider of healthcare products, including MDR, and in October 1998, Defendant Ingenix purchased the PHCS database from HIAA. As a result of these acquisitions, United

Healthcare owned the two principal and dominant producers of UCR determination databases used by or on behalf of commercial healthcare insurers and self-insured companies in the United States to determine the vast majority of UCR reimbursement amounts for out-of-network services.

40. In internal documents, United Healthcare, as the owner of the MDR database, acknowledged it was acquiring its "only competitor" by acquiring PHCS in October 1998.

41. The MDR database developed by Medicode was based on derived data, using a methodology comparable to what the United States government uses for setting reimbursement levels for Medicare. Rather than setting out rates for healthcare services based on what providers actually charge in the market place, the derived data used in MDR uses relative values assigned to each separate medical procedure multiplied by a conversion factor designed to account for the types of charges billed for a range of procedures that are deemed to be related. Thus, the derived charges used in MDR do not reflect usual, customary and prevailing charges by actual providers; rather, they are artificial prices designed for cost containment.

42. In 1973, HIAA developed PHCS premised on the use of nationwide historical charge data for surgical and anesthesia procedures obtained from numerous data contributors, including insurance companies, third-party payors, and self-insured companies. The PHCS databases were later expanded to include data regarding dental (1977), medical (1988), and drugs/medical equipment (1998).

43. PHCS was not designed to determine precise reimbursement amounts, but only to provide a general idea about prevailing charges in a geographic area based upon the limited data HIAA collected and upon which the databases were based.

44. When Ingenix acquired both MDR and PHCS, it kept them as separate databases, but merged the underlying data. Thus, the charge data gathered and processed by Ingenix for use in PHCS was the same data used by Ingenix to develop the conversion factors for purposes of developing MDR's derived data.

45. In approximately 2000, United Healthcare determined that MDR's reimbursement amounts for the most common procedures exceeded PHCS's by approximately 5%. As a result, United Healthcare decided to use PHCS as its exclusive means to determine its UCR reimbursements. At the same time, it continued to sell MDR to other companies as an alternative to PHCS for use in the benefit determination process.

46. There are systemic deficiencies that render the PHCS data unfit for the purpose of establishing UCR. These flaws include:

a. Underreporting the actual number of procedures performed in a geographic area, and often eliminating the highest charges for each type of medical procedure maintained in the PHCS database;

b. Including charges for medical procedures from other, and non-comparable, geographic areas, in which the provider charges were lower;

c. Failing to segregate procedures performed by providers of the same or similar skill and experience level, but rather, indiscriminately blending together all provider charges by procedure code without regard to skill or experience level;

d. Including charges for various procedures that are determined by a fee schedule with participating, "in-network" providers, and that reflect a discount from the "usual" or "customary" charge, thereby skewing the data below an accurate "usual or customary" rate;

e. Applying unsupported edits to exclude data that is not justified based on statistical analysis;

f. Accepting inadequate and uncontrolled data from subscribers which itself has been edited to exclude valid charges; and

g. Lacking quality control, such as basic auditing, to ensure the validity and authenticity of data submitted to it for inclusion in the database.

47. To the extent the Ingenix data reflects fewer than nine datapoints for a particular CPT code as part of PHCS, Ingenix then substitutes derived data using a similar methodology as MDR. The derived data for both PHCS and MDR are flawed, as the use of "relative values" is invalid because national values are used that are inappropriate for databases intended to calculate prevailing local charges, and the derived charges fail to report what providers actually charge in the marketplace, as required under the terms of United Healthcare's insurance plans. Derived data are also flawed because conversion factors are used that average data for numerous procedures and result in a statistically invalid, reduced amount.

48. The flaws and discrepancies in the Ingenix databases are so pervasive, and United Healthcare exercises such insufficient control and oversight over them, that they systematically result in inaccurate and reduced UCR amounts.

49. As a further method for justifying reductions in reimbursements to subscribers and their out-of-network providers, United Healthcare automatically reduces coverage for multiple procedures performed on the same day or during the same session, even if the additional procedures are unrelated to the initial procedure. By so doing, United Healthcare makes UCR determinations that dramatically reduce amounts for the secondary or other non-primary procedures well below accurate UCR rates.

50. United Healthcare fails to disclose its UCR data and the basis for its determinations. United Healthcare refuses to disclose its UCR data to its subscribers and to employers for whom United Healthcare functions as a claims administrator or fiduciary.

DEFENDANTS' BREACH OF CONTRACUAL UCR OBLIGATIONS TO PLAINTIFFS

Direct Insured Plaintiffs

51. David Finley's former employer, Professional Engineering Consultants, Inc., in Lake City, Florida, sponsored and paid monthly premiums for a group Choice health plan for its employees, including David Finley, which was directly insured by United Healthcare. David and Colleen Finley were directly insured by United Healthcare under this plan from February 1, 2000 until March 1, 2001, and contributed to the cost of the premiums for their group health plan.

52. Upon subscribing to the United Healthcare plan, the Finleys received a Certificate of Medical Insurance ("Certificate") stating that United Healthcare Insurance Company underwrote the group health plan, and that United HealthCare Services of Minnesota, Inc. was the plan administrator. This group plan is an indemnity plan under which the policyholder has the choice of selecting any healthcare provider and submitting a claim for reimbursement after receiving treatment.

53. The Finleys' Certificate specifies that there is an annual deductible of $200 per Member ($400 per family). Once this deductible is satisfied, United Healthcare is required to reimburse its subscribers, including the Finleys, 80% of Eligible Expenses. Once the out-of-pocket maximum is reached ($1,000 per member annually), benefits are supposed to increase to 100% of Eligible Expenses. "Eligible Expenses" are defined as: "the Reasonable and Customary Charges for Health Services received while coverage under the Policy is in effect."

54. The Certificate defines "Reasonable and Customary Charge" as "*the fees for Health Services which, in the judgment of the Company, do not exceed the general level of fees for the same Health Services provided under like and comparable circumstances, in the geographic area where the Health Services are provided.*"

55. On numerous occasions, United Healthcare made UCR determinations on claims submitted by the Finleys that reimbursed less than the stated percentage of their providers' actual charges. These UCR determinations resulted in the Finleys being obligated to pay not only their 20% coinsurance amount, but also that part of the providers' billed charge that exceeded the UCR amount as determined by United Healthcare.

56. United Healthcare failed to comply with the terms of the Finleys' group plan by making UCR determinations that reduced the stated percentage of their providers' charges without valid data to support such determinations.

57. The Finleys specifically requested relief from United Healthcare on various occasions, including the following dates: June 8, 2000; June 20, 2000; July 22, 2000; March 15, 2001; July 5, 2001. The Finleys also sent numerous letters to the Florida Department of Insurance, including on October 18, 2000; January 5, 2001; January 7, 2001. In spite of these requests, the Finleys, as stated, did not receive data, documentation, or adequate redress.

58. The Finleys, in writing and otherwise, repeatedly requested that United Healthcare provide specifics about these UCR determinations, and about why their providers' charges had been determined to exceed the UCR. Despite repeated requests for this information, in telephone conferences and in writing, United Healthcare never provided any data or other documentation for its UCR determinations. United Healthcare informed the Finleys on June 22, 2001: "you have exhausted the appeal process" and "we consider this matter to be closed."

Self-Funded Plaintiffs

American Airline Plaintiffs

59. As part of their employee benefits, each of the American Airlines Plaintiffs subscribed to a health care plan sponsored by American Airlines for which United Healthcare is the claims administrator. The American Airlines health care plan is a Choice plan, which

permits these Plaintiffs to receive medical care from out-of-network providers. Plaintiffs' Choice plan provides that policyholders will be reimbursed for 80% of the "usual and prevailing fee" for such services, which is defined as "[t]he maximum amount the plan will pay for medical services and supplies." The policy provides further:

> The following factors are considered when determining if a charge is within the usual and prevailing fee limits:
>
> The range and complexity of the services provided;
>
> The typical charges in the geographic area where the provider is located and other geographic areas with similar medical cost experience.

60. The term "usual and prevailing fee" as implemented and interpreted by United Healthcare is identical to the term "usual, customary and reasonable," or "UCR."

61. Michele Wilson was diagnosed with cancer in 1997 while pregnant with her second child. Because of her illness, Ms. Wilson received many medical treatments, including chemotherapy. She died on June 1, 2001.

62. On numerous occasions since 1997, United Healthcare made numerous UCR determinations on claims submitted by or on behalf of Ms. Wilson (or her children) that had the effect of covering less than the providers' actual charges.

63. United Healthcare failed to comply with the terms of the Wilsons' group plan by systematically making UCR determinations that had the effect of paying less than the stated percentage of their providers' charges without valid data to support such determinations, including but not limited to by relying on the Ingenix databases to set UCR even though they failed to take into account the range and complexity of the services provided and did not report the typical charges in the geographic area where the provider was located or in other geographic areas with similar medical cost experience.

64. The Wilsons, in writing and otherwise, repeatedly requested information and data from United Healthcare and from their group health plan administrator, American Airlines' Pension Benefits Administration Committee ("PBAC") about these UCR determinations. United Healthcare and the PBAC failed to provide them with information and data, claiming that the UCR data is proprietary and confidential.

65. American Airlines denied the Wilsons' appeals, and informed the Wilsons on several dates, including on January 22, 2001 and February 2, 2001: "The decision reached as a result of this appeal is final."

66. On numerous occasions during the Class Period, United Healthcare made UCR determinations on claims submitted by or on behalf of Peter Oborski that had the effect of covering less than the stated percentage of their actual providers' charges.

67. United Healthcare failed to comply with the terms of Oborski's group plan by systematically making UCR determinations that had the effect of covering less than the stated percentage of their providers' charges without valid data to support such determinations.

68. Oborski, in writing and otherwise, repeatedly requested information and data from United Healthcare and from the PBAC about these UCR determinations. United Healthcare and the PBAC failed to provide him with information and data, alleging that the UCR data is proprietary and confidential.

69. American Airlines denied Oborski's appeal and informed Oborski on May 17, 2001: "The decision reached as a result of this appeal is final." As a result, Oborski exhausted administrative remedies.

70. On numerous occasions during the Class Period, United Healthcare made UCR determinations on claims submitted by or on behalf of Sandra Taylor that had the effect of covering less than the stated percentage of her actual providers' charges.

71. United Healthcare failed to comply with the terms of Taylor's group plan by making UCR determinations that had the effect of covering less than the stated percentage of her providers' charges without valid data to support such determinations.

72. Taylor, in writing and otherwise, repeatedly requested information and data from United Healthcare and from the PBAC about these UCR determinations. United Healthcare and the PBAC failed to provide her with information and data, alleging that the UCR data are proprietary and confidential.

73. American Airlines denied Taylor's appeal and stated: "The decision reached on this appeal is final." As a result, Taylor exhausted administrative remedies.

74. On numerous occasions during the Class Period, United Healthcare made UCR determinations concerning claims submitted by or on behalf of Helene Coull, Michael and Susie Grisham, and Paul Steinberg, which had the effect of reimbursing them less than the stated percentage of their providers' actual charges.

75. United Healthcare violated its fiduciary obligations under ERISA by making UCR determinations without valid data to substantiate such determinations.

Other Self-Funded Plaintiffs

76. S. Joseph Domina received health benefits through a self-funded Choice health care plan offered by his former employer, Chase Manhattan Bank. Domina is currently retired. United Healthcare is the claims administrator for the health care plan that covered Domina.

77. On numerous occasions during the Class Period, United Healthcare made UCR determinations without valid data to support such determinations.

78. The Chase Manhattan Bank group plan defines "Reasonable and Customary" as "the *lowest* of":

- The prevailing charge of most other providers in the same or similar geographic area for the same or similar service or supply;
- The usual charge by the health care provider for the same or similar service or supply; or
- The provider's actual charge.

The plan then adds: "The insurance company will determine whether the price charged for a given service constitutes a reasonable and customary expense."

79. Domina repeatedly requested from both United Healthcare and his group health plan information and data regarding United Healthcare's UCR determinations. Despite his repeated requests, United Healthcare failed to provide such data or documentation and never provide adequate redress. United Healthcare breached its fiduciary duties to Domina.

80. Edward Mitchell, Jr. received health benefits through a self-funded Choice health care plan offered by his former employer, Osram Sylvania. United Healthcare is the claims administrator for the health care plan that covered Mitchell.

81. On numerous occasions during the Class Period, United Healthcare made UCR determinations as to Mitchell that reimbursed him less than the provider's actual charge without valid data to support the reduced amounts.

82. Mitchell exhausted his administrative remedies. By way of one such example, Osram Sylvania denied Mitchell's appeal of United Healthcare's reimbursement on July 23, 1999.

83. The Osram Sylvania group plan defines "Reasonable and Customary" as "an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it." It also states:

> The Company determines the prevailing charge. It takes into account all pertinent factors including
>
> The complexity of the service;
> The range of services provided;
> The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

84. Mitchell repeatedly requested from both United Healthcare and his group health plan information and data regarding United Healthcare's UCR determinations. Despite his repeated requests, United Healthcare and Osram Sylvania failed to provide such data or documentation and did not provide adequate redress.

85. Mitchell seeks equitable relief for United Healthcare's breach of fiduciary duties under ERISA.

Physician Plaintiffs

86. The Physician Plaintiffs do not belong to United Healthcare's physician network. They have not entered into a contractual relationship with United Healthcare, and they therefore remain free to charge their patients their actual charges for medical services.

87. Because they are out-of-network, the Physician Plaintiffs and other members of the Provider Class typically obtain assignments from their patients through which they are paid directly by United Healthcare for providing medical services to United Healthcare subscribers. These assignments do not alter the contractual or legal relationship between subscribers and United Healthcare, but merely provide a convenience to the subscriber to permit United Healthcare to provide payment to the providers rather than the subscribers.

88. The Physician Plaintiffs stand in the shoes of the subscribers who are insured by United Healthcare and who assigned such physicians their benefit claims, as well as those who in the future may assign such benefit claims. The Physician Plaintiffs have been injured as a result of United Healthcare's improper practices in reducing benefits for ONET services below proper

UCR amounts. The Physician Plaintiffs seek unpaid benefits for assigned claims that have been administratively exhausted and further seek equitable and declaratory relief against United Healthcare for breach of its fiduciary duty under ERISA.

Empire Plan Plaintiffs

89. The Empire Plan Plaintiffs subscribe to the Empire Plan, an indemnity health insurance program offered by Met Life through the State of New York and numerous New York State municipalities to New York's police officers, firefighters, and schoolteachers, among others. The terms and conditions of Empire Plan Plaintiffs' health care coverage are governed by the Empire Plan Certificate and other plan documents, including the group policies issued by Met Life.

90. "Reasonable and customary charge" is defined in the Empire Plan as 80% of "the lowest of":

* the actual charge for a service or supply; or
* the usual charge by the doctor or other provider for the same or similar service or supply; or
* the usual charge of other doctors or other providers of similar training or experience in the same or similar geographic area for the same or similar service or supply."

91. Although subscribers of the Empire Plan had originally contracted with Met Life to provide them health insurance, Met Life relinquished this function to United Healthcare. In approximately October of 1995, United Healthcare purchased Met Life's health care plans and entered into a contract with Met Life pursuant to which Met Life agreed to provide life insurance and dental benefits to United Healthcare's policyholders, while United Healthcare would provide health insurance benefits to Met Life's policyholders. The result is that certain of the group health insurance benefit programs, including the Empire Plan, have been and continue to be determined and controlled not by Met Life, the company with whom they contracted, but by

United Healthcare. Defendants failed to disclose United Healthcare's role to Empire Plan Plaintiffs until January 1, 2000.

92. Defendants Met Life and United Healthcare are, and were, required to provide benefits consistent with the terms of the Empire Plan. Defendants failed to comply with the Empire Plan by making UCR determinations that had the effect of paying less than the stated percentage of their providers' charges without valid data to support such determinations, and in breach of the express terms of the Empire Plan.

93. On numerous occasions during the Class Period, United Healthcare made UCR determinations concerning claims submitted by or on behalf of the Empire Plan Plaintiffs that had the effect of reimbursing them less than the correct percentage of a valid UCR amount.

94. Despite repeated requests for data and documentation with respect to its UCR determinations, United Healthcare and Met Life failed to provide such data or documentation, or gave wrong information about UCR determinations or UCR data.

95. The Empire Plan Plaintiffs have exhausted their administrative appeals. Also, exhaustion is not a requirement under the Empire Plan prior to pursuing litigation to enforce the terms of the contract.

All Plaintiffs

96. As a consequence of Defendants' uniform practices, Plaintiffs and members of the proposed classes, have been reimbursed in amounts less than what they should have been paid under their respective health care plans, or, for the Physician Plaintiffs, less than they should have been paid pursuant to the health care plans of their subscriber patients. United Healthcare pursued standard and uniform policies in making UCR determinations in a fashion that conflicted with its contractual obligations under such plans and, in addition, it has

misrepresented to its subscribers that the UCR amounts were calculated on the basis of valid data.

SUMMARY OF UNITED HEALTHCARE'S ANTITRUST AND RICO VIOLATIONS

97. As discussed above, HIAA developed PHCS in 1973, and continued to promulgate it until it was acquired by Defendant United Healthcare in October 1998. HIAA subsequently merged with the American Association of Health Plans, and the merged entity is known by the latter name. For purposes of this Complaint, however, HIAA will be used to refer to the pre-merger entity unless otherwise specified.

98. HIAA established several committees and advisory groups responsible for the substantive development and management of PHCS's databases. These committees were composed of various HIAA insurance company members and made all decisions concerning the design and operation of the PHCS databases. For purposes of this Complaint, Plaintiffs identify as "the HIAA Group" those insurance company HIAA members that were represented on HIAA's PHCS-related committees and HIAA's Board of Directors at the time of United Healthcare's acquisition of the PHCS database from HIAA in 1998, including the following companies, not all of which may presently exist: Liberty Mutual Insurance Company, The Principal Financial Group, The Guardian Life Insurance Company of America, CNA Insurance Companies, Allianz Life Insurance Company of North America, Home Life Financial Assurance Corporation, NYL Care Health Plans Inc., The Great-West Life Assurance Company, John Hancock Mutual Life Insurance Company, Employers Insurance of Wausau, General American Life Insurance Company, Transamerica Insurance Company, Mutual of Omaha Insurance Company, and State Farm Mutual Automobile Insurance Company.

99. Beginning in 1973 and continuing through the commencement of this action, PHCS data contributors submitted only four pieces of information per claim to be included in the

PHCS databases: date of service; a five-digit CPT Code that only partially describes the service(s) and procedure(s) provided; the provider's billed charge; and the first three digits of the zip code where service was provided.

100. The HIAA Group decided to limit the information provided by each data contributor to these four pieces of information. The HIAA Group decided not to require detailed information about the medical service, or any information about the provider of the service, even though such information is necessary for a properly functioning database used for reimbursement determinations.

101. In internal documents, HIAA acknowledged that PHCS's source data were too limited and that the quality of certain data was "questionable."

102. Despite the fact that PHCS did not capture sufficient information to provide anything remotely close to an accurate determination of prevailing charges, HIAA, acting in its shared interest with the HIAA Group, promoted PHCS, contrary to fact, as a comprehensive and reliable tool for UCR reimbursement.

103. By advisory opinion dated October 8, 1996, the United States Department of Labor ("DOL") opined that schedules reflecting standard UCR determinations for provider charges had to be disclosed to ERISA plan subscribers, instructing:

> [S]chedules … that contain information relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant or beneficiary's benefit entitlements … would constitute "instruments under which the plan is … operated."
>
> Thus, … the schedule of "usual and customary" fees … would be required to be disclosed to participants and beneficiaries.

(DOL #96-14A).

104. The HIAA Group expressed concerns about DOL #96-14A, including the concern that disclosure could undermine PHCS's ability to suppress the price paid for out-of-network claims.

105. The HIAA Group decided to continue to resist disclosure and ignore the DOL, and to advise PHCS users not to comply with DOL #96-14A.

106. The HIAA Group continued to resist disclosure of the information found in the PHCS databases to subscribers even after the DOL announced in 1998 its statutory interpretation that disclosure was required by all insurance companies that used such data to determine UCR.

107. From the mid-1980s until it sold PHCS to Ingenix in 1998, HIAA included a disclaimer with its PHCS user materials that is still used, virtually unchanged, by Ingenix, pursuant to which PHCS subscribers were informed that HIAA or Ingenix were not endorsing, approving or recommending the use of any of the PHCS data as establishing UCR rates:

> The DATA, whether actual charge data, derived charge data, conversion factor data or length of stay data, are provided to the LICENSEE for information purposes only. The HIAA disclaims any endorsement, approval or recommendation of the DATA. There is neither a stated nor an implied "reasonable and customary" charge, either actual or derived; neither is there a stated nor an implied "reasonable and customary" conversion factor or length of stay. Any interpretation and/or use of the DATA by the LICENSEE is solely and exclusively at the discretion of the LICENSEE. THE LICENSEE MUST NOT represent the DATA in any way other than as expressed in this paragraph #7.

108. Despite its knowledge that PHCS did not provide accurate UCR determinations, the HIAA Group, in order to reduce competition among themselves, agreed to continue to use PHCS to make UCR determinations, to inform their subscribers that such determinations were unassailable due to their use of PHCS and to refuse to disclose information regarding PHCS to their subscribers or out-of-network physicians. Contemporaneously, the HIAA Group agreed to refrain from requiring the submission of more detailed information from PHCS data contributors

(including themselves) because the lack of specific information enabled PHCS to combine lower cost services (such as those provided by inexperienced physicians and non-physician healthcare providers) with higher cost services (such as those provided by experienced physicians) resulting in overall savings to PHCS users.

109. Despite continuing to use the HIAA disclaimer after purchasing PHCS, Defendant United Healthcare has also used, and continues to use, the PHCS data as a primary source for its UCR determinations.

110. As a condition to closing under the purchase agreement between HIAA and Ingenix, Ingenix was obligated to enter into a so-called "Cooperation Agreement" with HIAA that had a term of 10 years.

111. The Cooperation Agreement allowed HIAA (and the HIAA Group) to continue its involvement with the development and operation of PHCS despite the acquisition and placed controls on Ingenix's operation of PHCS, which continue to date, including:

(a) HIAA and Ingenix would create a committee, called a "Liaison Committee," on which they each had to have at least two representatives;

(b) the Liaison Committee was to meet "as necessary, but in no event less than twice a year," for the "purposes of discussing, evaluating, recommending and providing market insight relative to (i) Ingenix's management of the Products [*i.e.*, the Ingenix Databases], and (ii) maintaining or improving the availability, quality, usefulness and consistency of the Products";

(c) Ingenix would "give due consideration to the views of HIAA's representatives on the Liaison Committee";

(d) Ingenix would "maintain the consistency of the input and output formats" of PHCS's core products, the Medical, Dental and Surgical Fee Schedule Databases (the "Core Products"), until December 31, 2000, after which the Liaison Committee "will have the opportunity to provide input to Ingenix

on Product enhancements or replacements, including any changes to input formats";

(e) Ingenix may "price and revise prices for the Core Products" only in accordance with the Cooperation Agreement;

(f) Ingenix would charge HIAA members 50% less than non-HIAA members for all Core Products;

(g) Ingenix would waive all fees for current HIAA members that continue to contribute data at the same level of contribution that they were then contributing; and

(h) Ingenix, except in limited cases, would not increase the prices of the Core Products by more than 10% per year for the subscribers of any 1998 Product.

112. The Cooperation Agreement also required that Ingenix protect the identity of all companies submitting data to it and take "all commercially reasonable measures so that no claims-paying organization nor any customer or user of such products can identify any of the data as having been contributed by the organization that submitted it." As a direct result, no provider or beneficiary could determine whether a particular provider's data had been included in the PHCS databases.

113. In addition, as part of the Asset Purchase Agreement for PHCS, United Healthcare agreed to become a member of HIAA, with a significant portion of the payment United Healthcare made to HIAA under the agreement representing a membership fee.

114. Today, the vast majority of commercial insurance companies use the Ingenix Databases for determining UCR amounts in reimbursing claims for out-of-network charges. Indeed, United Healthcare uses its ownership of the Ingenix Databases to promote them as the

"industry standard" for determining UCR amounts in order to provide their improperly reduced payments with the appearance of legitimacy and accuracy.

115. In furtherance of antitrust and RICO conspiracies, Defendant United Healthcare, primarily through its wholly owned subsidiary Ingenix, Inc., produces, promotes and uses falsified PHCS and MDR databases that are designed to reduce payments for covered medical services well below the market levels of usual, customary and reasonable fee rates for out-of-network services that the subscribers are contractually entitled to receive.

116. United Healthcare, HIAA and the HIAA Group conspired and agreed to promote and use the Ingenix Databases to determine UCR reimbursement amounts to restrain trade and reduce competition by reducing UCR determinations well below market levels to induce health insurance companies to use the Ingenix Databases, or suffer competitive disadvantage.

117. The primary design and effect of the conspiracy is to artificially restrain the pricing of medical services in numerous local markets across the United States to the detriment of medical providers, while also harming healthcare plan beneficiaries through reduced UCR reimbursements. United Healthcare, HIAA and the HIAA Group have conspired to lower their and other healthcare insurers' costs of providing such insurance through anticompetitive means that result in the shifting of these costs to subscribers and providers.

118. Through United Healthcare's control of the Ingenix Databases primarily used by insurers nationwide to make UCR determinations, United Healthcare, HIAA and the HIAA Group have conspired to artificially reduce UCR determinations well below market levels and thereby artificially inflate subscribers' out-of-pocket costs for out-of-network services. This conspiracy has had the direct effect of lowering the payment of benefits for ONET services

below levels to which subscribers and their ONET providers are entitled pursuant to the terms of the applicable healthcare plans.

119. United Healthcare, HIAA and the HIAA Group entered into the conspiracy to reduce benefits through reduced UCR determinations based on their understanding that, in the numerous, concentrated healthcare plan local markets around the country, where a few, large insurers serve the majority of subscribers due to the rapid consolidation in the industry that has taken place in the last decade, healthcare plan insurers wield dominant buyer power over their in-network physicians, and implement rates for medical services that are well below the level that would prevail in a competitive market.

120. Improperly lowered UCR is designed to, and does, pressure out-of-network physicians to become in-network providers, enabling United Healthcare and other insurers to exert further cost controls over them, and pressures subscribers to forego treatment by out-of-network providers, all for the design and effect of artificially suppressing the prices paid for medical services.

121. Subscribers obtaining services from out-of-network physicians are left with significant out-of-pocket expenses, or forced to forego such out-of-network services entirely to avoid such expenses.

122. In addition, physicians have suffered the loss of revenues due to the illegal exercise of buyer power by United Healthcare and the HIAA Group to suppress the prices paid for medical services in local markets in the United States.

123. Subscribers obtaining services from out-of-network physicians are left with significant out-of-pocket expenses.

124. United Healthcare and the HIAA Group conspired to ensure that their subscribers, as well as physicians, were kept in the dark regarding these anticompetitive actions by asserting that the methodologies and editing processes used in perpetuating the Ingenix Databases were confidential and proprietary and by prohibiting users of the Ingenix Databases from disclosing information to subscribers.

125. This secrecy created a figurative "black hole" from which it was impossible for subscribers and physicians to obtain any information regarding the data found in the Ingenix Databases, or from which they were derived, as well as all of the information that would reveal how the data was improperly manipulated.

126. United Healthcare, HIAA and the HIAA Group's actions violate the Sherman Act by restraining trade and competition among United Healthcare, the HIAA Group and other insurers for the prices they pay for medical services, the amounts they pay for UCR reimbursements, and the means for determining UCR amounts, causing injury to subscribers and physicians. In the course of accomplishing this restraint of trade, United Healthcare also violated RICO by having conducted, and continuing to conduct, the operation and management of an enterprise, comprised of itself, the HIAA Group, users of the Ingenix Databases and the entities whose healthcare insurance plans United Healthcare administers, through a pattern of racketeering activity.

127. United Healthcare was motivated to convert funds from the guaranteed benefits to which subscribers were entitled as reimbursement for out-of-network charges for several reasons, including, by way of example, the concomitant reduction of health insurer costs and increase in health insurer profits. Moreover, the substantial revenue United Healthcare receives from PHCS

and MDR users for its license of the Ingenix Databases is predicated on demonstrating savings in out-of-network reimbursement.

128. United Healthcare's control of the Ingenix Databases facilitates the conspiracy to exercise dominant buying power over medical service providers in local healthcare insurer markets by forcing subscribers and physicians in-network, such that United Healthcare and the HIAA Group are able to suppress artificially the price paid for medical services.

129. After the expiration of the 26-month period in the Cooperation Agreement during which United Healthcare was prohibited from changing PHCS, United Healthcare changed the Ingenix Databases, to further facilitate the conspiracy, by combining certain features of PHCS and MDR, including using PHCS's databases in MDR's methodology, thereby insinuating PHCS's flaws and manipulated data into MDR, and vice versa.

130. In marketing PHCS, United Healthcare promised, and continues to promise, that PHCS users will achieve substantial costs savings, including a "16:1 return on investment."

UNITED HEALTHCARE'S FEE SCHEDULE DATABASE SCHEME, AND THE HIAA GROUP'S INVOLVEMENT IN THE CONTROL OF THE PHCS DATABASE AND FACILITATION OF THE ANTICOMPETITIVE SCHEME

131. The HIAA Group and United Healthcare had, and continue to have, a conscious commitment and an agreement that operates to restrain competition for the reimbursement of subscribers for out-of-network services, in part through United Healthcare's operation and maintenance of its falsified Ingenix Databases for the purpose of systematically under-reimbursing for such services ("Fee Schedule Database Scheme").

132. United Healthcare, in part through its acquisition agreements with HIAA regarding PHCS, obtained exclusive and permanent control over historical and current source data used in the Ingenix Databases, and perpetuates this control by:

a) requiring the licensees and users of the Ingenix Databases to execute written Master Services and Licensing Agreements that contain comprehensive confidentiality and non-disclosure provisions;

b) preventing Plaintiffs and other subscribers, as well as their employers, from obtaining or reviewing the Ingenix Databases and the source information on which they were based, making the Ingenix Databases impervious to effective scrutiny or challenge;

c) claiming the Ingenix Databases to be "confidential" and "proprietary" even though use of proprietary databases violates ERISA, the federal law governing most of the Plaintiffs' health plans;

d) coercing the users of the Ingenix Databases into breaching their disclosure obligations under ERISA by threatening to terminate their licensed use of the Ingenix Databases if such users disclose the Ingenix Databases to subscribers or others; and

e) prohibiting disclosure of historical UCR determination databases, and thereby perpetuating a monopoly over such data.

133. Through United Healthcare's use of the Master Services and Licensing Agreements and the HIAA Group's assertions regarding the proprietary and confidential nature of charge data, the large majority of PHCS data contributors, including United Healthcare and the insurance companies of the HIAA Group, do not provide their own charge data to any other entity that produces or seeks to develop UCR determination databases.

134. At all relevant times, United Healthcare understood or should have understood the Ingenix Databases' flaws and problems, acknowledging, for example, in or about October 1998, that the data collected for the PHCS databases was "questionable" and "of limited use and value."

135. Nonetheless, United Healthcare, in concert with the HIAA Group, promoted and continues to promote the Ingenix Databases as providing exactly what it disclaims: usual, reasonable and customary charges.

136. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, manipulated and continues to manipulate the Ingenix Databases to enhance the

conspirators' ability to restrain trade by reducing its own and the HIAA Group's UCR reimbursement obligations and concomitant insurance coverage, thereby reducing their expenses.

137. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, manipulated and continues to manipulate the Ingenix Databases to suppress the price paid for medical services provided through group health plans and purchased by United Healthcare and the HIAA Group.

138. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, eliminated and continues to eliminate from the PHCS databases all data from the higher end of the universe of provider charges, thereby unjustifiably decreasing the range of charges from which UCR amounts were and are derived and on which PHCS users' reimbursement obligations were and are based.

139. United Healthcare recognized that medical charges in more affluent areas typically exceed those in less affluent areas. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, purposely created and perpetuates geographic areas composed of separate localities that had and have economically dissimilar costs such that the lower charges in the economically less affluent areas act to offset the higher charges in the more affluent areas, resulting in lower UCR reimbursement determinations, higher out-of-pocket charges to subscribers and reduced costs to PHCS users, including United Healthcare and the HIAA Group.

140. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, manipulated and continues to manipulate the Ingenix Databases by failing to segregate fees charged in connection with procedures performed by providers of the same or similar skill, training and experience level. Rather, it aggregates charges without regard to a

provider's skill, training or experience level in order to offset the lower fees a less trained, experienced or skilled provider would charge compared to the higher fees a more skilled, trained or experienced provider would charge, thereby further reducing its and PHCS users' UCR reimbursement amounts and their own expenses.

141. United Healthcare, in concert with the HIAA Group, but unknown to its subscribers, further manipulates the Ingenix Databases by including charges for various procedures that are determined by a fee schedule with participating in-network providers, which reflect a discount from the providers' usual and customary charges, thereby reducing UCR reimbursement amounts and their own expenses.

142. United Healthcare, acting in concert with the HIAA Group, but unknown to its subscribers, took and continues to take the following additional actions, among others, to manipulate the Ingenix Databases to reduce unjustifiably the UCR reimbursement amounts below market values and in restraint of trade:

a) using edits and screens that eliminate high charges and skew the distribution of charges downward;

b) using edits and screens that reference national means that eliminate high charges and skew the distribution of charges downward;

c) using previously manipulated data from the immediately prior time period for additional edits and screens, which serve to reduce charges and artificially level the data and minimize the effect of actual increases in prices;

d) using flawed data and formulas to derive UCR amounts;

e) facilitating, promoting, and permitting the use of data that is pre-edited by data contributors;

f) failing to distinguish the number of medical providers whose charges are reflected (*i.e.*, one provider could account for all of the charges);

g) providing financial incentives to those data contributors that provide data that has a higher acceptance rate (*i.e.*, needs less editing) and penalizing those with a lower

acceptance rate to coerce those insurers providing data to self-edit and remove higher charges and costs;

h) accepting and using data that reflects negotiated and discounted charges (rather than fee for services charges);

i) accepting and using data that fails to distinguish among medical providers, such as between medical doctors and other healthcare providers (*e.g.*, physician assistants, nurses midwives, and social workers);

j) establishing charges for low frequency, specialized, procedures by using data for less costly high-volume procedures;

k) failing to verify or audit data contributors or data contributions;

l) failing to account for the place of service (*e.g.*, hospitals, medical centers, doctors' offices) where charges differ; and

m) improperly using Average Wholesale Price (AWP) to determine UCR for medications. AWP purports to reflect the price that the drug manufacturer sells wholesale quantities to, such as a national pharmacy chain.

143. As part of their anticompetitive scheme, United Healthcare and the HIAA Group's wrongful actions included and continue to include:

a) increasing the amount of out-of-pocket expenses subscribers pay for out-of-network physicians or charges at a level above which would have existed in the absence of such anticompetitive actions;

b) falsely marketing the Ingenix Databases as providing correct UCR reimbursement amounts;

c) allowing and encouraging misinformation about the Ingenix Databases;

d) preventing subscribers, users of the Ingenix Databases and self-insured companies that retain United Healthcare to administer their claims from obtaining or reviewing PHCS data, insulating the Ingenix Databases from challenge, and perpetuating its restraint of trade;

e) claiming that the Ingenix Databases are "proprietary" for the alleged reason that disclosure would undermine the claimed cost control effect of the Ingenix Databases, even though use of a proprietary database violates ERISA;

f) reducing, or eliminating, competition regarding the level of reimbursements for services provided by out-of-network physicians;

g) eliminating competition for the development and use of UCR determination databases and other potential means for determining UCR reimbursements amounts;

h) providing "legal assistance" to help defend the Ingenix Databases from legal challenge;

i) shifting the burden for paying for specialized care in particular from insurers to beneficiaries; and

j) driving subscribers from out-of-network providers to in-network providers, thereby saving insurers and other third-party payors money at the expense of subscribers, who are denied the benefit of out-of-network services for which they paid and pay higher premiums.

144. The design and effect of the anticompetitive scheme is to artificially suppress the prices for medical services by improperly under-reimbursing amounts for out-of-network services, thereby forcing subscribers and physicians in-network, where United Healthcare and the HIAA Group have conspired to exercise illegal buying power in negotiating severely discounted contracted rates in local markets where the number of healthcare insurers is concentrated.

UNITED HEALTHCARE'S ADDITIONAL ACTIONS IN FURTHERANCE OF ITS FEE SCHEDULE DATABASE SCHEME

A. The Stale Data Scheme

145. Although new versions of the Ingenix Databases are released semi-annually to create the impression that their values are current, each new semi-annual release is filtered through and designed to include previously manipulated data that is carried over from prior releases. Accordingly, each new release of the Ingenix Databases always lags well behind the actual UCR amounts, precisely as United Healthcare intended. By calculating benefits based on the Ingenix Databases - instead of based upon actual UCR amounts – the insurance companies that use Ingenix Databases were and are under-paying claims based on the Ingenix Databases.

B. The Cover-up Schemes

146. United Healthcare represented that it reimbursed subscribers or caused subscribers to be reimbursed for out-of-network medical charges on the basis of UCR amounts, but intentionally failed to disclose the true basis on which it determined reimbursements.

147. United Healthcare caused and causes harm to subscribers through its aforementioned schemes, including increasing subscribers' out-of-pocket payments.

148. United Healthcare knew full well that its reimbursements to subscribers derived from the Ingenix Databases were understated. It engaged in extensive schemes to preclude subscribers from learning that they had been duped.

149. United Healthcare:

(a) repeatedly represented in plan documents, insurance policies, summary plan descriptions, certificates of coverage and other materials that it would cause claims for out-of-network medical services to be reimbursed on UCR amounts, but failed to disclose that it intended to reimburse these claims based on the Ingenix Databases, which it knew or should have known unjustifiably understated UCR amounts;

(b) repeatedly represented in plan documents, insurance policies, summary plan descriptions, certificates of coverage and other materials that it would use a "modified database" to determine UCR to give its reimbursement decisions an appearance of legitimacy and regularity, but failed to disclose that this "modified database" was one of the Ingenix Databases, through which it knew or should have known unjustifiably understated UCR amounts;

(c) repeatedly represented in explanations of benefits, appeal determination letters, and other materials, that it reimbursed for out-of-network charges in accordance with the terms of the United Healthcare Plans, but failed to disclose that it caused these claims to be reimbursed based on the Ingenix Databases, which it knew knew or should have known were databases that unjustifiably understated UCR amounts, and that the reimbursements were not in accordance with the terms of the United Healthcare Plans;

(d) repeatedly knew or should have known that its EOBs, appeal determination letters, and other materials, represented that it processed

> claims for out-of-network charges consistent with the terms of the applicable United Healthcare Plans, but failed to disclose that it reimbursed those claims based on the Ingenix Databases, such that the reimbursements violated the terms of the applicable plans; and

(e) never disclosed the underlying data and methodology upon which the Ingenix Databases were designed and constructed and precluded all of the users of the Ingenix Databases from disclosing any PHCS or MDR related information through confidentiality and non-disclosure agreements in order to prevent discovery of and complaints about the false payment schemes, and thereby make the discovery of the false payment schemes less likely than if the underlying data and methodology were disclosed.

150. Although internally acknowledging the limited value of the data contained in the Ingenix Databases, United Healthcare routinely cited the purported comprehensiveness and accuracy of such data in communications to subscribers. It also concealed its management and control of PHCS.

151. For example, in its January 18, 2001 letter to plaintiff S. Joseph Domina, written nearly two and one-half years after it acquired PHCS, United Healthcare represented that HIAA still owned PHCS: "[United Healthcare] utilizes the Health Insurance Association of America (HIAA) to obtain information on prevailing health charges in the United States. HIAA's Prevailing Healthcare Charges System (PHCS) is the nation's largest, most comprehensive, up-to date database of provider charges. The PHCS program, operated by HIAA…."

152. Similarly, in its May 3, 2001 letter to Mr. Domina, United Healthcare continued to refer to HIAA as an outside, independent, arbiter of UCR determinations:

> The reasonable and customary amount was determined by the Health Insurance Association of America. They are an outside data collecting company who United Healthcare utilizes for reasonable and customary information. They are not required to provide their data collection information to United Healthcare.

153. In its May 3, 2001 letter to Mr. Domina, United Healthcare rejected Mr. Domina's request for specific information as to how his particular UCR amounts for several

procedures were determined, concealing its ownership of HIAA and stating "once again we do not have access to HIAA's database so I am unable to provide you with the details," notwithstanding that it did have access to the databases it both owned and controlled.

154. United Healthcare also made false statements to governmental authorities to whom subscribers complained about United Healthcare's UCR determinations.

155. For example, United Healthcare made numerous false statements in a July 17, 2002, letter to the Attorney General of the State of New York, which stated, in pertinent part, as follows:

> Each procedure and its charge is captured for the database within a provider's geographic area. The assignment of geographic areas recognizes the differences in patterns of health care charges in different localities, therefore, a metropolitan area would be considered separately from a rural area. The 90th percentile reflects 90 percent of the charges for a particular service in a specific geographic area. This method of setting allowances accommodates the fees of physicians charging more than the average for their community.

156. United Healthcare knew or should have known its statements to the Attorney General of the State of New York were false because:

(a) each procedure and its charge in an area are *not* captured by the Ingenix Databases, and, in fact, the databases fail to determine what percentage of procedures and their charges is captured in an area;

(b) since the measure of charges is unknown and many providers' charges were edited out, the 90th percentile does not reflect 90 percent of the charges in an area;

(c) the geographic groupings used by the Ingenix Databases combine rural and metropolitan areas; and

(d) the Ingenix Databases do not accommodate the fees of physicians charging more than average, particularly because the database lumps together non-physician, inexperienced physician and experienced physician charges and has no provider-identification or provider-specific

information.

EXAMPLES OF PLAINTIFF'S UCR DETERMINATION EXPERIENCES, ANTITRUST HARM, AND DEFENDANTS' RICO PREDICATE ACTS

157. Plaintiffs have experienced hundreds of intentionally false UCR determinations. Several brief examples follow to illustrate the harm to them from United Healthcare's conduct undertaken in furtherance of the anticompetitive conspiracy and illegal conspiracies and agreement.

158. In April 2002, Cynthia Falk unexpectedly went into labor and gave birth while traveling in Philadelphia, hours away from her home, requiring her to seek emergency medical services at Chester County Hospital.

159. United Healthcare considered the neonatologists that treated her newborn's medical conditions to be out-of-network providers.

160. Ms. Falk's newborn son's critically ill condition required that he remain hospitalized in a neonatal intensive care unit for over six weeks.

161. Ms. Falk submitted claims for reimbursement for the neonatal care for her newborn in an amount exceeding $9,000.

162. United Healthcare's false UCR reimbursement determinations left Ms. Falk liable for over $4,000. United Healthcare did not disclose in the EOB it sent to Ms. Falk by U.S. mail that the UCR determination came from the Ingenix Databases that intentionally and unjustifiably understated UCR determinations.

163. On November 9, 2000, Dr. Cody, performed a partial mastectomy on Plaintiff Mary Gilmartin. Dr. Cody's charges for the mastectomy equaled approximately $9,500.

164. United Healthcare considered Dr. Cody to be an out-of-network provider.

165. Ms. Gilmartin submitted a claim for reimbursement to United Healthcare, which rendered a UCR charge determination of $6,701.43. United Healthcare mailed Ms. Gilmartin the EOB containing misrepresentations and omissions regarding its use of the Ingenix Databases in reaching this determination. United Healthcare's UCR charge determination left Ms. Gilmartin, a retired teacher, liable for approximately $3,000.

166. Ms. Gilmartin appealed to United Healthcare. United Healthcare mailed its denial, dated March 27, 2001, via the U.S. mail. United Healthcare's appeal denial contained misrepresentations and omissions designed to prevent a meaningful appeal, including that it did not disclose to Ms. Gilmartin that the UCR determination came from the Ingenix Databases, which intentionally and unjustifiably understated UCR determinations.

167. During 1998 and 1999, Ms. Stravitz received cancer treatment at Memorial Sloan Kettering ("MSK") in New York City, one of the preeminent facilities for treating cancer in the United States.

168. United Healthcare considered MSK to be an out-of-network provider.

169. As an example, for a treatment Ms. Stravitz received on December 30 1998, she submitted claims for reimbursement to United Healthcare totaling approximately $3,000.

170. United Healthcare responded by way of an EOB sent via U.S. Mail and dated April 12, 1999, and disallowed virtually the entire bill, allowing a UCR charge of only $263.14, and leaving Ms. Stravitz liable for $2,700 on that bill alone. United Healthcare's EOB to Ms. Stravitz rejecting her reimbursement request contained information based on the Ingenix Databases, which United Healthcare knew intentionally and unjustifiably understated UCR determinations, and contained misrepresentations and omissions.

171. On July 31, 1999, Ms. Stravitz had surgery at MSK. Ms. Stravitz submitted claims for reimbursement of $9,395 in surgical charges. By an EOB dated September 23, 1998, and sent via U.S. Mail, United Healthcare only allowed about 60% of the claim. This EOB contained misrepresentations and omissions, including information based on the Ingenix Databases, which United Healthcare knew intentionally and unjustifiably understated UCR determinations.

172. United Healthcare's false UCR reimbursement determination left Ms. Stravitz liable for over $3,000.

173. David and Colleen Finley were subscribers in the Professional Engineering Consultants health plan, which was fully insured and administered by United Healthcare.

174. One of the Finleys' four sons, Jordan Finley, needed intensive speech therapy as a result of a cleft palate suffered at birth.

175. United Healthcare considered the providers who treated all of the Finleys, including Jordan, to be out-of-network.

176. The Finleys submitted claims for reimbursement to United Healthcare totaling over $15,000. By an EOB sent through the U.S. mail, United Healthcare denied a significant portion of the Finleys' claim on UCR grounds. The EOB contained misrepresentations and omissions, including information based on the Ingenix Databases that United Healthcare knew intentionally and unjustifiably understated UCR determinations.

177. United Healthcare's false UCR reimbursement determinations left the Finleys liable for over $3,000.

178. Clifford Wilson is an American Airlines pilot, whose late wife, Michele, while pregnant with their second child, was stricken with breast cancer. Her cancer metastasized and resulted in her death on June 1, 2001 at age 40.

179. United Healthcare considered the oncologists and other providers who treated Michele Wilson, including those at MSK, to be out-of-network.

180. The Wilsons submitted claims for reimbursement to United Healthcare in excess of $100,000. By EOBs sent through the U.S. mail, United Healthcare denied a significant portion of the Wilson's claim on the basis of UCR. The EOB contained misrepresentations and omissions, including information based on the Ingenix Databases, which United Healthcare knew intentionally and unjustifiably understated UCR determinations.

181. United Healthcare's false UCR reimbursement determinations left Cliff Wilson and his two young children liable for tens of thousands of dollars.

182. Paul Steinberg is an American Airlines pilot who lives outside of Reno, Nevada.

183. Paul Steinberg, and his son Cole, have sought medical treatment from numerous out-of-network providers.

184. Paul Steinberg has submitted claims for reimbursement to United Healthcare in excess of tens of thousands of dollars. By EOBs sent through the U.S. mail, United Healthcare denied numerous claims for reimbursement, in whole or in part, for Paul Steinberg. The EOBs contained misrepresentations and omissions, including information based on the Ingenix Databases that United Healthcare knew intentionally and unjustifiably understated UCR determinations.

185. United Healthcare's improper UCR determinations for Paul Steinberg and his son Cole left him liable for thousands of dollars.

186. S. Joseph Domina is a retired Chase Manhattan Bank executive.

187. United Healthcare considered the physician who performed vascular surgery on Mr. Domina's wife, Vittoria, to be an out-of-network provider. Vittoria is covered as a beneficiary under her husband's United Healthcare plan.

188. Mr. Domina submitted claims for reimbursement to United Healthcare in excess of $10,000. By EOB sent through the U.S. Mail, United Healthcare denied a significant portion of Mr. Domina's claim on UCR grounds. The EOBs contained misrepresentations and omissions, including information based on the Ingenix Databases that United Healthcare knew intentionally and unjustifiably understated UCR determinations.

189. United Healthcare's false UCR reimbursement determination left Mr. Domina liable for over $3,000.

190. Joan Lawrence is a subscriber in the Empire Plan, which is fully insured and administered by United Healthcare.

191. Ms. Lawrence has been diagnosed with a malignant glioma brain tumor, and has elected to be treated by a group of highly trained specialists considered by United Healthcare to be out-of-network.

192. United Healthcare has refused to cover thousands of dollars in bills from Ms. Lawrence's out-of-network providers, stating that their charges are in excess of UCR, leaving Ms. Lawrence responsible for the unpaid portions.

193. In denying Ms. Lawrence's appeals of the UCR reductions, United Healthcare misrepresented in three letters sent through the U.S. mails on August 19, 2006, September 6, 2006, and December 20, 2006, its use of the PHCS database as follows:

> Under the terms of the plan, coverage is provided for expenses within a reasonable allowance. To determine "allowable and reasonable" expenses, we

> use independent research from across the health care industry. This includes over 200 million records of fees charged by health care providers for surgical and non-surgical procedures in many different geographic locations. We also consider variations in fees that may be due to complications or unusual circumstances.

194. In rejecting Ms. Lawrence's argument that their out-of-network providers were specialists with substantial training and experience that should be taken into account, based, in particular, on the language in the Empire Plan that states that UCR will be determined based on charges of other providers of "similar training and experience," United Healthcare confirmed its position in a letter sent through the U.S. mails on March 14, 2007 that it was not obligated to take into account the training and experience of providers in making UCR determinations:

> [T]his language means that United HealthCare will compare your provider's charges with the charges of all providers who are similarly trained and licensed by the State of New York to administer the same or similar services and who practice in the same pre-defined geographic area determined by an aggregation of various three-digit zip codes.

195. United Healthcare's representations to the Lawrences to justify its actions were false and misleading. Among other things, the PHCS database is not based on "independent research from across the nation," but is developed by United Healthcare's own wholly owned subsidiary, using undisclosed and faulty edits to exclude valid data and manipulate the reported results. United Healthcare also intentionally misled the Lawrences by omitting the fact that, on numerous occasions, derived data is used rather than actual charges of providers and that the Ingenix Databases upon which it relied unjustifiably understated UCR determinations. Further, United Healthcare admitted in its final denial letter to the Lawrences that it intentionally ignores express language in the Empire Plan requiring it to take into account the "training and experience" of providers so as to allow it to reduce its benefit payments below proper amounts.

196. These examples of subscribers United Healthcare harmed through its use of the Ingenix Databases are illustrative and not all-inclusive. All subscribers whose UCR was determined by the Ingenix Databases suffered harm, including monetary harm.

197. Dr. Attkiss is and has been an out-of-network provider with United Healthcare.

198. Since at least 2001, Dr. Ericson has been an out-of-network provider with United Healthcare.

199. United Healthcare has made numerous UCR reimbursement determinations for its subscribers treated by the Physician Plaintiffs and other AMA members. In addition, the Physician Plaintiffs and numerous AMA, MSSNY and MSMA members have obtained assignments from United Healthcare subscribers.

200. In the EOBs that United Healthcare sent via U.S. Mail to such subscribers, and to the Physician Plaintiffs and members of the AMA, MSSNY and MSMA, United Healthcare represented that an improperly reduced amount was the UCR for their geographic area.

UNITED HEALTHCARE'S ACTIONS VIOLATE THE SHERMAN ACT AND RICO LAWS

201. The conduct of United Healthcare, and the HIAA Group, as well as the users of the Ingenix Databases, involve and affect substantial sums of money sent in interstate trade and commerce: (i) by Ingenix Databases users to United Healthcare for the license and use of the Ingenix Databases; (ii) by subscribers to pay their out-of-network physicians; (iii) by United Healthcare and the users of the Ingenix Databases, including members of the HIAA Group, to reimburse subscribers for costs incurred from their using out-of-network physicians; (iv) by United Healthcare and the users of the Ingenix Databases directly to out-of-network physicians in connection with services rendered to subscribers; and (v) by United Healthcare in its promotion and marketing of the Ingenix Databases.

202. The number of victims and the number of instances in which they have been victimized are vast and the financial loss subscribers suffered as a direct result of these improperly reduced payments adds up to hundreds of millions of dollars, or more. United Healthcare perpetrated its improper payment schemes on individuals who are under medical treatment, often for severe or debilitating illnesses.

203. In addition, these actions affect consumers both in New York and elsewhere as subscribers in each state have received improperly reduced reimbursement amounts from United Healthcare and members of the HIAA Group and paid increased out-of-pocket costs for out-of-network services obtained from providers in each state.

Sherman Act § 1 Violation

204. There are three relevant product markets affected by the anticompetitive conduct alleged herein, the second of which is a subset of the first: (i) group healthcare plans with out-of-network reimbursement benefits based on UCR determinations (whether HMO, PPO, indemnity, or self-insured ERISA plans); (ii) group healthcare plans with out-of-network reimbursement benefits based on UCR determinations that are offered to multistate corporations with offices, and therefore, employees, in multiple cities across the United States; and (iii) the market for the purchase of medical services.

A. Group Healthcare Plans With Out-of-Network Benefits

205. The first product market affected by United Healthcare, HIAA and the HIAA Group's restraint of trade in violation of § 1 of the Sherman Act is the market for group healthcare plans with out-of-network reimbursement benefits. The vast majority of such plans base the reimbursement amounts for out-of-network services on UCR determinations. There is a sharp distinction between plans that do not provide reimbursement for out-of-network benefits,

and those that do provide such benefits with regard to the interchangeability of such plans for the purposes of consumers.

206. Group healthcare plans with out-of-network reimbursement benefits represent an appropriate product market because healthcare insurance plans that do not offer such out-of-network benefits are not suitable alternatives to the significant number of consumers who wish to take advantage of the higher quality of services, increased physician and provider choices and larger choice of procedures available in plans with out-of-network benefits. Insurance companies are able to charge higher premiums for such plans due to consumer demand for such increased choices and level of services. The demand of consumers for such plans is inelastic, as consumers that prefer plans offering out-of-network benefits do not switch regularly to plans without such benefits. Thus, there is little cross-elasticity of demand between plans with out-of-network benefits and plans without out-of-network benefits.

207. The relevant geographic product market for group healthcare insurance plans with out-of-network benefits is local. Insurers compete to provide plans with out-of-network benefits combined with in-network benefits based on medical provider networks in the areas where subscribers work and live. The companies offering such plans compete, in part, on the basis of local provider networks. Subscribers that prefer plans with out-of-network benefits still are not likely to switch to a plan with a network outside their local area, thus, Metropolitan Statistical Areas and other local regions are the appropriate geographic market for this product market.

B. The Sub-Market of Group Healthcare Plans with Out-of-Network Benefits Offered to Large, National Corporations

208. The second relevant product market affected by United Healthcare, HIAA and the HIAA Group's restraint of trade in violation of § 1 of the Sherman Act is a sub-market of the primary product market defined immediately above, and is the market for group healthcare plans

with out-of-network benefits offered to large, national corporations such as American Airlines. The vast majority of such plans also base the reimbursement amounts for out-of-network services on UCR determinations. Large national corporations with employees working in locations across the country require the products offered by health care insurers that are also national in scope.

209. In a *New York Times* interview related to United Healthcare's acquisition of Oxford Health Insurance, United Healthcare Group's then-chief executive, William W. McGuire, acknowledged that UHC would be able to attract large corporations with headquarters in the New York area and with workers throughout the country, and that such companies were largely out of reach for Oxford, which is a regional healthcare insurer and focuses on small to midsize employers.

C. The Market for the Purchase of Medical Services

210. The product market affected by United Healthcare, HIAA and the HIAA Group's illegal conspiracy to exercise buying power in violation of § 1 of the Sherman Act is the market for the purchase of medical services in all specialties and procedures as identified by CPT codes. The vast majority of purchases of such medical services are made through group health plans, be they from in-network or out-of-network physicians and medical providers.

211. The relevant geographic product market for the purchase of medical services is local. Subscribers normally seek to obtain medical services where they work and live. Group healthcare plan insurers offer plans based on local physician networks to employers in these local markets, thus, Metropolitan Statistical Areas and other local regions are the appropriate geographic market for this product market.

Antitrust Injury

212. Health insurance companies, such as United Healthcare and those in the HIAA Group, insure or provide benefits for the vast majority of medical services through group health plans.

213. The overwhelming majority of UCR reimbursement determinations made in the United States for subscribers of group health plans with out-of-network benefits are based on the Ingenix Databases.

214. United Healthcare and the HIAA Group's agreement and actions in restraint of trade have reduced competition under group health plans for the amount subscribers are reimbursed for costs they incur for out-of-network services.

215. Since United Healthcare is one of the nation's largest healthcare insurers, the anticompetitive conduct described herein has substantially reduced competition for UCR reimbursements, in both relevant product markets defined above, between United Healthcare and the other healthcare insurer users of the Ingenix Databases that compete in each product market, to the detriment of subscribers and their assignees.

216. Where United Healthcare competes in a local region against one of the members of the HIAA Group, competition for such UCR reimbursement amounts is reduced to an even greater extent as each company is aware of their conspiracy and agreement to improperly lower UCR amounts and forego competition regarding such out-of-network benefits, all to the detriment of subscribers and their assignees.

217. Similarly, competition between United Healthcare and other healthcare insurers that provide group health plans to large national corporations has also been reduced by the conspiracy and agreement to improperly reduce UCR amounts by the limited number of insurers that offer group health plans to such employers.

218. Further, United Healthcare and the HIAA Group's agreement and actions in restraint of trade have reduced competition for the use and development of methods other than the Ingenix Databases for UCR determination in both product markets to the further detriment of subscribers and their assignees.

219. Numerous local markets in the United States, including several in New York, such as New York City, are served by a small number of healthcare insurers, such that these insurers hold significant buying power of medical services in the local market.

220. United Healthcare and the HIAA Group's agreement and actions are an illegal exercise of dominant buyer power with the design and effect of artificially suppressing the prices paid by insurers for medical services in these local markets.

221. As a result of their anticompetitive actions, United Healthcare and the HIAA Group have caused subscribers to incur out-of-pocket expenses for out-of-network services substantially higher than such expenses would have been in the absence of such actions, reduced the quality and quantity of benefits and features available to consumers in group health plans offering out-of-network benefits (especially those offered to large national employers), reduced the availability, use and development of alternative methods for UCR determinations other than the Ingenix Databases, harmed physicians by artificially suppressing the prices paid for their services, and reduced the choices for medical services available to subscribers.

RICO Harm

222. United Healthcare intentionally injured subscribers for whom it was and is either the insurer or the claims administrator by causing them to be underpaid the benefits to which they are contractually entitled. United Healthcare then converted those withheld funds for its own direct or indirect financial gain. United Healthcare also profited through its licensing of its falsified Ingenix Databases.

223. United Healthcare has caused and continues to cause subscribers to be deprived of the full reimbursement payments that rightfully belong to them through the implementation of several separate, but related, false payment schemes and cover-up schemes. As previously alleged in greater detail, United Healthcare intentionally acted with the purpose and effect of shifting the cost of out-of-network care from itself (and other users of the Fee Schedule Database) to subscribers and their assignees.

Reservation of Rights as to Dismissed Claims

224. Plaintiffs reserve the right to seek appellate review of all claims previously alleged and dismissed by the Court, and the tolling of the statute of limitations, without the need to reallege such claims in the Complaint.

CLASS ACTION ALLEGATIONS

Class Claims under ERISA, RICO and the Sherman Act

225. Subscriber Plaintiffs, Physician Plaintiffs, and the New York Empire Plan Plaintiffs (the "Class Plaintiffs"), bring this action on their own behalf and on behalf of the following class (the "Class"):

> All persons who are, or were, at any time since March 15, 1994 (the "Class Period"), subscribers in any Choice plan who received medical services from an out-of-network provider and for whom United Healthcare made UCR determinations for less than the stated percentage of their providers' actual charges.

226. All Class Plaintiffs seek compensatory and treble damages, as well as appropriate equitable and declaratory relief, under RICO and the Sherman Act (since July 15, 2000). The Medical Association Plaintiffs and the New York Union Plaintiffs seek appropriate equitable and declaratory relief under RICO and the Sherman Act (since July 15, 2000).

227. Subscriber Plaintiffs and Physician Plaintiffs seek equitable and declaratory relief against United Healthcare for its breaches of fiduciary duty under ERISA.

228. The Direct Insured Plaintiffs seek unpaid benefits individually and on behalf of a class under ERISA for United Healthcare's breach of the terms of the group health plans. The Physician Plaintiffs also seek unpaid benefits individually for assigned claims that have been administratively exhausted and on behalf of a class of assigned claims for United Healthcare's breach of group health plans and ERISA.

229. The membership of the Class is so numerous that joinder of all members is impracticable. United Healthcare is one of the largest health insurers in the United States, insuring more than 14 million policyholders nationwide. Thus, the numerosity requirement of Rule 23 is easily satisfied.

230. Common questions of law and fact exist as to all members of the Class and predominate over any questions affecting solely individual members of the Class, including: whether United Healthcare systemically made UCR determinations without valid data to support such determinations based on standard and uniform policies and practices; whether United Healthcare systemically failed to satisfy its duty to disclose the data or other documentation underlying its UCR determinations; whether United Healthcare violated ERISA; and whether United Healthcare violated RICO as a result of its actions, including its conspiracy with the HIAA Group to control and manipulate the Ingenix databases

231. With respect to the claims arising under the Sherman Act, common questions of law and fact exist as to all Class members and predominate over any questions affecting solely individual members of the Class, including whether United Healthcare and the HIAA Group conspired:

a) to restrain trade by intentionally and systemically rendering UCR reimbursement amount determinations well below market levels to decrease their insurance coverage and reimbursement obligations for out-of-network provider charges;

b) to restrain trade by reducing competition between United Healthcare and the HIAA Group's members regarding the quality and quantity of coverage for out-of-network services;

c) to restrain trade by reducing competition between United Healthcare and the HIAA Group's members for the use and development of alternative UCR determination methods other than the use of the Ingenix Databases; and

d) to reduce the competition for the purchase of medical services provided through group health plans between United Healthcare and the HIAA Group's members by colluding to suppress the price paid for such services through United Healthcare's control of Ingenix Databases and the dominant buying power held by these insurers in the nation's local markets.

232. The claims of the named Plaintiffs in the Class are typical of the claims of the Class members because, as a result of the conduct alleged, United Healthcare breached its statutory and fiduciary obligations to Plaintiffs and the Class through and by a uniform pattern or practice as described.

233. The named Plaintiffs in the Class will fairly and adequately protect the interests of the members of the Class, are committed to the vigorous prosecution of this action, have retained counsel competent and experienced in class litigation and have no interests antagonistic to or in conflict with those of the classes or subclasses. As such, the named Plaintiffs are adequate class representatives.

234. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for Defendants.

235. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the Class is impracticable. Furthermore, because the damages suffered by individual class members may be relatively small, the expense and burden of individual litigation make it impossible for the class members

individually to redress the harm done to them. Given the uniform policy and practices at issue, there will also be no unusual difficulty in the management of this action as a class action.

The American Airlines Subclass

236. Separately, the American Airlines Plaintiffs bring their ERISA claims on behalf of the following subclass (the "American Airlines Subclass"):

> All current or former subscribers to the health insurance plan offered by American Airlines and administered by United Healthcare, at any time since March 15, 1994 who received medical services from an out-of-network provider and for whom American Airlines and/or United Healthcare made UCR determinations for less than the stated percentage of their providers' actual charges.

237. The membership of the American Airlines Subclass is so numerous that joinder of all members is impracticable. American Airlines is a large, national company, with thousands of employees who were members of its health care plan. Thus, the numerosity requirement of Rule 23 is easily satisfied.

238. Common questions of law and fact exist as to all members of the American Airlines Subclass and predominate over any questions affecting solely individual members of the Subclass, including: whether United Healthcare systemically made UCR determinations without valid data to support such determinations based on standard and uniform policies and practices; whether United Healthcare systemically failed to satisfy its duty to disclose the data or other documentation underlying its UCR determinations; and whether American Airlines violated its duties and obligations under ERISA by failing to supervise or provider proper oversight over the actions of United Healthcare and permitting the improper UCR determinations at issue herein.

239. The claims of the named Plaintiffs in the American Airlines Subclass are typical of the claims of the Subclass members because, as a result of the conduct alleged, American Airlines and United Healthcare have breached their statutory, contractual and fiduciary obligations to Plaintiffs and the Class through and by a uniform pattern or practice as described.

240. The named Plaintiffs in the American Airlines Subclass will fairly and adequately protect the interests of the members of the Subclass, are committed to the vigorous prosecution of this action, have retained counsel competent and experienced in class litigation and have no interests antagonistic to or in conflict with those of the classes or subclasses. As such, the named Plaintiffs are adequate class representatives.

241. The prosecution of separate actions by individual members of the American Airlines Subclass would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for Defendants.

242. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the American Airlines Subclass is impracticable. Furthermore, because the damages suffered by individual class members may be relatively small, the expense and burden of individual litigation make it impossible for the class members individually to redress the harm done to them. Given the uniform policy and practices at issue, there will also be no unusual difficulty in the management of this action as a class action.

The Empire Plan Subclass

243. Separately, the Empire Plan Plaintiffs bring their claims on behalf of the following subclass (the "Empire Plan Subclass"):

> All Empire Plan Plaintiffs who are, or were, at any time since March 15, 1994, subscribers in any Choice plan who received medical services from an out-of-network provider and for whom United Healthcare made UCR determinations for less than the stated percentage of their providers' actual charges.

244. The Empire Plan Plaintiffs raises state claims on behalf of the Empire Plan Subclass for breach of contract and deceptive acts and practices under New York's General Business Law § 349 against both United Healthcare and Met Life.

245. The membership of the Empire Plan Subclass is so numerous that joinder of all members is impracticable. There are more than one million Empire Plan members residing in New York, thousands of whom have been adversely affected by United Healthcare's UCR determinations. Thus, the numerosity requirement of Rule 23 is easily satisfied for the Empire Plan Subclass.

246. Common questions of law and fact exist as to all members of the Empire Plan Subclass and predominate over any questions affecting solely individual members of the Subclass, including whether United Healthcare breached its contractual obligations under the Empire Plan by systematically making UCR determinations based on invalid data that failed to comply with the express and unambiguous UCR definition contained with the Empire Plan, and whether, through its actions, United Healthcare violated New York's GBL § 349.

247. The claims of the named Plaintiffs in the Empire Plan Subclasses are typical of the claims of the Subclass members because, as a result of the conduct alleged, United Healthcare has breached its statutory and contractual obligations to Plaintiffs and the Subclass through and by a uniform pattern or practice as described.

248. The named Plaintiffs in the Empire Plan Subclass will fairly and adequately protect the interests of the members of the Subclass, are committed to the vigorous prosecution of this action, have retained counsel competent and experienced in class litigation and have no interests antagonistic to or in conflict with those of the classes or subclasses. As such, the named Plaintiffs are adequate class representatives.

249. The prosecution of separate actions by individual members of the Empire Plan Subclass would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for Defendants.

250. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the Empire Plan Subclass is impracticable. Furthermore, because the damages suffered by individual class members may be relatively small, the expense and burden of individual litigation make it impossible for the class members individually to redress the harm done to them. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this action as a class action.

Florida RICO Subclass

251. Plaintiffs David and Colleen Finley assert claims on their own behalf and on behalf of a class of all persons in the United States who are, or were, during the applicable statute of limitations for Florida RICO policyholders residing in Florida who received medical services from out-of-network providers under United Healthcare Plans and as to whom United Healthcare made UCR determinations at least in part using the Ingenix Databases (collectively, the "Florida RICO Subclass").

252. The Florida RICO Subclass members are so numerous that joinder of all members is impracticable. United Healthcare is one of the largest health insurers in the United States, and insures hundreds of thousands of subscribers in the State of Florida. Thus, the numerosity requirement of Rule 23 is easily satisfied for the Florida RICO Subclass.

253. Common questions of law and fact exist as to all Florida RICO Subclass members and predominate over any questions affecting solely individual members of the Florida RICO Subclass, including whether United Healthcare and the HIAA Group conspired to manipulate the Ingenix databases so as to permit improper reductions in benefits based on flawed UCR determinations, thereby harming Florida residents.

254. The Finleys' claims are typical of the claims of the Florida RICO Subclass members because, as a result of the conduct alleged herein, United Healthcare systematically violated the Florida RICO Act as described herein.

255. The Finleys will fairly and adequately protect the interests of the members of the Florida RICO Subclass, are committed to the vigorous prosecution of this action, have retained competent counsel experienced in class litigation and have no interests antagonistic to or in conflict with those of the Florida RICO Subclass. As such the Finleys are adequate class representatives for the Florida RICO Subclass.

256. The prosecution of separate actions by individual members of the proposed Florida RICO Subclass would create a risk of inconsistent or varying adjudications, which would establish incompatible standards of conduct for defendants.

257. A class action is superior to other available methods for the fair and efficient adjudication of this controversy because joinder of all members of the Florida RICO Subclass is impracticable. Furthermore, in that the damages suffered by individual Florida RICO Subclass members may be relatively small, the expense and burden of individual litigation make it impossible for the Florida RICO Subclass members to redress individually the harm done to them. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this action as a class action.

COUNT I

UNITED HEALTHCARE'S FAILURE TO COMPLY WITH GROUP PLANS IN VIOLATION OF ERISA

258. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

259. Under the provisions of the insurance policies provided to the Direct Insured Plaintiffs by United Healthcare, United Healthcare functions as the insurer and as the "plan administrator." The insurance policies here at issue are "welfare benefit plans" as such term is interpreted under ERISA.

260. United Healthcare breached its obligations under such group health plans to the Direct Insured Plaintiffs by making reduced UCR determinations without valid data to substantiate its determinations.

261. United Healthcare had, and continues to have, an actual conflict of interest in exercising its discretion to determine UCR amounts, because the cost of such determinations is paid directly by United Healthcare, such that the profit or "savings" occasioned by UCR reductions are reaped by United Healthcare.

262. The Direct Insured Plaintiffs seek unpaid benefits as to the claims that have been administratively exhausted. Pursuant to 29 U.S.C. § 1132(a)(1)(B), the Direct Insured Plaintiffs are entitled to their unpaid benefits and are entitled to declaratory and injunctive relief related to enforcement of the terms of their plans, and to clarify future benefits. In addition, the Direct Insured Plaintiffs seek counsel fees, costs, prejudgment interest, and other like relief.

COUNT II

UNITED HEALTHCARE'S FAILURE TO COMPLY WITH GROUP PLANS IN VIOLATION OF ERISA: PROVIDERS' CLAIMS AS ASSIGNEES

263. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

264. The Physician Plaintiffs are entitled to enforce the terms of the plans, as assignees of directly insured subscribers, under 29 U.S.C. § 1132(a)(1)(B), for whom United Healthcare

has made UCR determinations without valid data, and to obtain appropriate relief under such provision.

265. United Healthcare breached the terms of the plans of such directly insured subscribers, in whose shoes the assignee physicians stand, by making UCR determinations that had the effect of reimbursing less than the stated percentage of their providers' actual charges without valid data to substantiate such determinations.

266. The Physician Plaintiffs are also entitled to prejudgment interest, costs, expenses, and attorneys' fees.

COUNT III

UNITED HEALTHCARE'S BREACH OF FIDUCIARY DUTIES OF LOYALTY AND CARE UNDER ERISA

267. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

268. The Subscriber Plaintiffs and the Physician Plaintiffs (as assignees of ERISA subscribers) are entitled to assert a claim for relief for United Healthcare's breach of the fiduciary duties of loyalty and care under 29 U.S.C. § 1132(a)(3).

269. In its capacity as the insurer, plan administrator, claims administrator or fiduciary of ERISA group plans, United Healthcare is a fiduciary.

270. The duty of loyalty imposed on ERISA fiduciaries, such as United Healthcare, prohibits self-dealing and financial arrangements that benefit the fiduciary at the expense of plan subscribers under 29 U.S.C. § 1106.

271. United Healthcare breached its duty of loyalty to the Subscriber and Physician Plaintiffs by making reduced UCR determinations without valid data to substantiate such

determinations, by omitting material information about Ingenix databases from its subscribers, and by making misrepresentations about its UCR determinations or the Ingenix databases.

272. By engaging in the conduct described above, United Healthcare failed to act with the care, skill, prudence, and diligence that a prudent plan administrator would use in the conduct of an enterprise of like character or to act in accordance with the documents and instruments governing the plan. 29 U.S.C. § 1104(a)(1)(B) and (D)).

273. United Healthcare further breached its duty of care by failing to act solely in their interest, or for the exclusive purpose of providing benefits to participants and subscribers. 29 U.S.C. § 1104(a)(1)(A).

274. As a direct and proximate cause of such breach of fiduciary duties of loyalty and care, the Subscriber and Physician Plaintiffs have been and continue to be damaged and are entitled to injunctive and declaratory relief to remedy such statutory breaches, including removal of United Healthcare as a fiduciary.

COUNT IV

UNITED HEALTHCARE'S FAILURE TO PROVIDE FULL AND FAIR REVIEW UNDER ERISA

275. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

276. United Healthcare functions as the "plan administrator" within the meaning of such terms under ERISA when it insures a group health plan, or when it is designated as the plan administrator for such plan, including the plans of the Direct Insured Plaintiffs. They are entitled to assert a claim for relief under 29 U.S.C. § 1132(a)(3).

277. Although United Healthcare was obligated to do so, it failed to provide a "full and fair review" and otherwise failed to make necessary disclosures pursuant to 29 U.S.C. § 1133 (and its regulations) for the Direct Insured Plaintiffs.

278. The Direct Insured Plaintiffs were proximately harmed by United Healthcare's failure to comply with 29 U.S.C. § 1133 and are also entitled to injunctive and declaratory relief to remedy United Healthcare's continuing violation of these provisions.

COUNT V

UNITED HEALTHCARE'S FAILURE TO PROVIDE REQUIRED INFORMATION AND SPDS UNDER ERISA

279. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

280. As the plan or plan administrator for the group health plans of the Direct Insured Plaintiffs, United Healthcare was obligated to supply certain information to such subscribers, and was also obligated to furnish accurate materials summarizing such group health plans, known as Summary Plan Description ("SPD") materials.

281. United Healthcare's conduct in making UCR determinations that had the effect of reimbursing less than the stated percentage of the Direct Insured Plaintiffs providers' actual charges without valid data to support such determinations, in addition to not describing its UCR determinations accurately to subscribers, makes United Healthcare liable under ERISA.

282. United Healthcare breached its duty to supply information requested by the Direct Insured Plaintiffs under 29 U.S.C. § 1024(b)(4). United Healthcare is therefore liable under 29 U.S.C. § 1132(c).

283. In addition, United Healthcare breached its duty to provide accurate SPD materials to the Direct Insured Plaintiffs under 29 U.S.C. § 1022.

284. As a proximate cause of United Healthcare's violation of its obligations under ERISA as described above, the Direct Insured Plaintiffs were harmed, and continue to be harmed, and are entitled to injunctive and declaratory relief.

COUNT VI

UNITED HEALTHCARE'S BREACH AS A CO-FIDUCIARY UNDER ERISA

285. The allegations contained above are realleged and incorporated as if fully set forth herein.

286. The Self-Funded Plaintiffs bring this claim against United Healthcare under 29 U.S.C. § 1105. United Healthcare caused its co-fiduciaries who serve as plan administrators of the Choice health care plans for which United Healthcare serves as claims administrator to breach their fiduciary duties and, by so doing, United Healthcare breached its co-fiduciary obligations. The Self-Funded Plaintiffs proceed under 29 U.S.C. § 1132(a)(3).

287. Under 29 U.S.C. § 1105, a fiduciary is liable for a breach of fiduciary responsibility of another plan fiduciary if it either participates knowingly in such breach, or knows of such breach and fails to make reasonable efforts to remedy the breach.

288. United Healthcare prevented self-funded employers, such as American Airlines and Chase Manhattan Bank, from complying with such plans' obligations to conform with the terms of their group health plans. In addition, United Healthcare prevented such self-funded employers from complying with their disclosure obligations under 29 U.S.C. § 1024(b)(4), and thus violated 29 U.S.C. § 1105. Such self-funded employers function as ERISA fiduciaries with regard to such plans. United Healthcare is also an ERISA fiduciary vis-a-vis such plans.

289. United Healthcare knew of the plans' failure to disclose the UCR data, and failed to make reasonable efforts to remedy the plans' breach.

290. The Self-Funded Plaintiffs are entitled to equitable relief, including declaratory and injunctive relief, to remedy United Healthcare's breach as a co-fiduciary.

COUNT VII

UNITED HEALTHCARE'S VIOLATION OF CLAIMS PROCEDURE PROVISIONS UNDER ERISA

291. The allegations contained above are realleged and incorporated as if fully set forth herein.

292. United Healthcare is an insurance company that is subject to regulation under the insurance laws of more than one state. Further, United Healthcare processes benefit claims for self-funded plans providing claims filing and notices of decision to policyholders in such plans.

293. United Healthcare is an insurance company which therefore must comply with claims procedures defined by federal law (e.g., 29 C.F.R. § 2560.503-1) for Subscriber Plaintiffs. The Subscriber Plaintiffs are entitled to seek judicial relief if an insurance company fails to comply with federal law. 29 U.S.C. § 1132(a)(3).

294. United Healthcare violated these claim procedure regulations by discouraging appeals, omitting required or material information from communications with subscribers, and otherwise engaged in conduct that rendered its claims procedures and appeals process unfair to subscribers.

295. As a proximate cause of its violation of such regulation, the Subscriber Plaintiffs have been harmed, and are entitled to equitable relief, including declaratory and injunctive relief.

COUNT VIII

AMERICAN AIRLINES' FAILURE TO COMPLY WITH GROUP PLANS IN VIOLATION OF ERISA

296. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

297. Under the provisions of the insurance policies provided to the American Airlines Plaintiffs, American Airlines functions as the insurer and as the "plan administrator" as such terms are interpreted under ERISA. American Airlines breached its obligations under such insurance policies to the American Airlines Plaintiffs.

298. American Airlines had, and continues to have, an actual conflict of interest in exercising its discretion to determine UCR amounts, because the cost of such determinations is paid directly by American Airlines, such that the profit or "savings" occasioned by UCR reductions are reaped by American Airlines.

299. American Airlines acquiesced in or relied on UCR determinations that had the effect of reimbursing American Airlines Plaintiffs less than the stated percentage of their providers' actual charges without valid data to support such determinations. To the extent American Airlines used United Healthcare's UCR determinations, American Airlines is liable because its subscribers received lesser benefits than they were entitled to under the terms of American Airlines' group health plans.

300. The American Airlines Plaintiffs are entitled to unpaid benefits and declaratory and injunctive relief related to enforcement of plan terms or clarification of future benefits under 29 U.S.C. § 1132(a)(1)(B) for all claims that have been administratively exhausted. In addition, the American Airlines Plaintiffs seek counsel fees, costs, prejudgment interest, and other like relief.

COUNT IX

AMERICAN AIRLINES' BREACH OF FIDUCIARY DUTY OF LOYALTY AND CARE UNDER ERISA

301. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

302. In its capacity as the plan administrator of the group plan of the American Airlines Plaintiffs, American Airlines is a fiduciary, 29 U.S.C. § 1002(21)(A). As a fiduciary, American Airlines is obligated to comply with the terms of its health care plans, including the terms and conditions of subscriber agreements and other plan documents.

303. The duty of loyalty imposed on ERISA fiduciaries, such as American Airlines, prohibits self-dealing and financial arrangements that benefit the fiduciary at the expense of plan participants and subscribers. 29 U.S.C. § 1106.

304. American Airlines breached its duty of loyalty to the American Airlines Plaintiffs by acquiescing in or relying on UCR determinations without valid data to support such determinations. American Airlines has profited from such UCR determinations. To the extent American Airlines delegated the function of making UCR determinations to United Healthcare, such delegation does not insulate or otherwise protect American Airlines from the consequences of United Healthcare's improper UCR determinations.

305. American Airlines further breached its duty of loyalty to all American Airlines Plaintiffs by making misrepresentations related to its UCR determinations and related to United Healthcare's UCR determinations, or by omitting material information to such subscribers.

306. By engaging in the conduct described above, American Airlines failed to act with the care, skill, prudence, and diligence that a prudent plan administrator would use in the conduct

of an enterprise of like character or to act in accordance with the documents and instruments governing the plan. (29 U.S.C. § 1104(a)(1)(B) and (D)). The American Airlines Plaintiffs proceed under 29 U.S.C. § 1132(a)(3).

307. American Airlines further breached its duty of care to the American Airlines Plaintiffs by failing to act solely in their interest, or for the exclusive purpose of providing benefits to participants and subscribers under 29 U.S.C. § 1104(a)(1)(A), including by providing inaccurate or incomplete information to subscribers.

308. As a direct and proximate result of American Airlines' breach of the fiduciary duties of loyalty and care, the American Airlines Plaintiffs have been and continue to be damaged. The American Airlines Plaintiffs are entitled to injunctive and declaratory relief to remedy American Airlines' breach of its fiduciary duties of loyalty and care.

COUNT X

AMERICAN AIRLINES' FAILURE TO PROVIDE FULL AND FAIR REVIEW UNDER ERISA

309. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

310. American Airlines functions as the "plan administrator" within the meaning of such terms under ERISA when it insures a group health plan, or when it is designated as the plan administrator for such plan, as is the case for the American Airlines Plaintiffs.

311. American Airlines failed to provide a "full and fair review" and otherwise failed to make necessary disclosures pursuant to 29 U.S.C. § 1133 (and the accompanying regulations) for the American Airlines Plaintiffs. The American Airlines Plaintiffs are entitled to assert a claim for relief under 29 U.S.C. § 1132(a)(3).

312. The American Airlines Plaintiffs were proximately harmed by American Airlines' failure to comply with 29 U.S.C. § 1133, and are also entitled to injunctive and declaratory relief to remedy American Airlines' continuing violation of these provisions.

COUNT XI

AMERICAN AIRLINES' FAILURE TO PROVIDE REQUIRED INFORMATION AND SPDS UNDER ERISA

313. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

314. American Airlines breached its duty to supply information requested by the American Airlines Plaintiffs under 29 U.S.C. § 1024(b)(4). American Airlines is therefore liable under 29 U.S.C. § 1132(c).

315. In addition, American Airlines breached its duty to provide accurate information in Summary Plan Description ("SPD") materials distributed to the American Airlines Plaintiffs under 29 U.S.C. § 1022.

316. As a proximate cause of American Airlines' violation of its obligations under ERISA as described above, the American Airlines Plaintiffs were harmed, and continue to be harmed, and are entitled to injunctive and declaratory remedies.

COUNT XII

BREACH OF CONTRACT AND THE COVENANT OF GOOD FAITH

317. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

318. By virtue of its role as insurer of the Empire Plan, Met Life is obligated to adhere to the terms of the group health plan with Empire Plan policyholders. United Healthcare is

obligated by its October 1995 agreement with Met Life to comply with the terms of applicable contracts with Empire Plan subscribers.

319. United Healthcare and Met Life breached their contractual obligations to the Empire Plan Plaintiffs by making UCR determinations that had the effect of reimbursing less than the stated percentage of their providers' actual charges without valid data to support such determinations.

320. United Healthcare and Met Life's conduct deprived the Empire Plan Plaintiffs of the full value of their insurance benefits. Defendants United Healthcare and Met Life impaired the rights of the Empire Plan Plaintiffs to receive the benefits to which they are entitled, and acted in a manner inconsistent with their justified expectations.

321. Defendants United Healthcare and Met Life consistently failed to provide data and documentation in violation of the contractual and other rights of the Empire Plan Plaintiffs.

322. Defendants United Healthcare and Met Life violated the implied covenant of good faith and fair dealing in their conduct toward the Empire Plan Plaintiffs.

323. As a result of United Healthcare and Met Life's conduct as detailed above, the Empire Plan Plaintiffs suffered damages. In addition, the Empire Plan Plaintiffs and the New York Union Plaintiffs are entitled to declaratory and injunctive relief to remedy United Healthcare and Met Life's persistent ongoing failure to disclose information and data to subscribers and other contractual violations.

COUNT XIII

DECEPTIVE ACTS AND PRACTICES UNDER NEW YORK GENERAL BUSINESS LAW § 349

324. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

325. New York General Business Law § 349 specifically prohibits deceptive acts or practices in the conduct of any business, trade or commerce. The statute confers a private right of action on aggrieved persons.

326. United Healthcare and Met Life are subject to the requirements and prohibitions of New York law, including New York's law prohibiting deceptive trade practices.

327. United Healthcare and Met Life engaged in various misrepresentations and omissions in sale and/or plan documents that are directed toward consumers, including potential subscribers, to induce such consumers to elect, or to continue, Empire Plan membership. In addition, United Healthcare and Met Life omitted material facts to the Empire Plan Plaintiffs.

328. United Healthcare and Met Life misrepresented the amounts they will pay to or on behalf of the Empire Plan Plaintiffs for treatment they receive from their chosen out-of-network provider. United Healthcare and Met Life's conduct is materially deceptive and is "consumer-oriented."

329. Met Life delegated responsibility for making UCR determinations to United Healthcare, or allowed United Healthcare to make UCR determinations, or otherwise failed to disclose the true roles being performed by United Healthcare and Met Life. Such conduct was deceptive and violated the rights of the Empire Plan Plaintiffs.

330. United Healthcare and Met Life engaged in other deceptive practices. For example, they systematically advised Empire Plan Plaintiffs that they had valid data for their UCR determinations when they did not. They also advised Empire Plan Plaintiffs that "HIAA" produced the UCR data without disclosing that United Healthcare had acquired and operated the UCR database.

331. United Healthcare and Met Life also failed to disclose the data they were relying on, and thereby acted deceptively. They also failed to disclose that they lacked valid data to support their UCR determinations.

332. United Healthcare and Met Life's misrepresentations and failure to disclose were material, and had the effect of harming the Empire Plan Plaintiffs.

333. United Healthcare's and Met Life's violations of the New York General Business Law § 349 were purposeful, entitling the Empire Plan Plaintiffs to monetary relief and payment of counsel fees. In addition, the Empire Plan Plaintiffs and the New York Union Plaintiffs are entitled to declaratory and injunctive relief to ensure that United Healthcare and Met Life comply with state law.

COUNT XIV

VIOLATION OF SHERMAN ACT SECTION 1 – (UCR Reimbursement)

334. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

335. Through the means alleged above, United Healthcare conspired and, agreed and/or combined with the HIAA Group to restrain trade by agreeing to use the Ingenix Databases to reduce UCR reimbursement amounts for charges related to out-of-network services to well below true market levels, thereby reducing the coverage provided under their own or

administered health insurance plans and shifting the cost of charges that they should have covered onto the backs of such plans' subscribers.

336. United Healthcare continues to violate § 1 of the Sherman Act, and has violated it throughout the statute of limitations period, for which the Subscriber Plaintiffs and the Empire Plan Plaintiffs are entitled to relief, pursuant to Sections 4 and 16 of the Clayton Act, including declaratory, injunctive and monetary relief, including treble damages, attorney's fees, court costs and other relief deemed appropriate by the Court.

337. The Physician Plaintiffs and the members of the Medical Association Plaintiffs have been harmed due to certain of their patients and members being compelled to seek medical treatment only from in-network physicians because it is too costly for them to obtain treatment from out-of-network physicians. This is because the subscribers' insurers reimburse them for out-of-network service charges well below the amounts that would be paid in the absence of United Healthcare and the HIAA Group's restraint of trade.

338. As a result of the anticompetitive actions alleged above, United Healthcare and the HIAA Group have caused the Physician Plaintiffs and the members of the Medical Association Plaintiffs who are out-of-network with United Healthcare and the HIAA Group's group health plans, to lose patients who are forced to forego seeking treatment from out-of-network physicians.

339. United Healthcare's and the HIAA Group's aforementioned restraint of trade in violation of § 1 of the Sherman Act entitles the Physician Plaintiffs and the Medical Association Plaintiffs to declaratory and injunctive relief under Section 16 of the Clayton Act.

COUNT XV

VIOLATION OF SHERMAN ACT SECTION 1 – (Medical Services Buyer Power)

340. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

341. Through the means alleged above, United Healthcare conspired, agreed and combined with the HIAA Group to fix and suppress the prices paid for the purchase of medical services provided to subscribers under group health plans in local markets throughout the United States by artificially reducing the amounts to be paid for out-of-network services via the Ingenix Databases, thereby driving subscribers to obtain medical services from in-network physicians, over whom United Healthcare and the HIAA Group hold significant buying power in local markets to further suppress the prices they pay to in-network physicians. The resulting harm is that subscribers are forced to either accept significant out-of-pocket expenses for obtaining out-of-network services or forego the benefit for which they have paid additional premiums and obtain services from in-network physicians.

342. United Healthcare violated and continues to violate § 1 of the Sherman Act and has violated it throughout the statute of limitations period, for which the Subscriber Plaintiffs and the Empire Plan Plaintiffs are entitled to declaratory and injunctive relief pursuant to Sections 16 of the Clayton Act.

343. With respect to claims maintained by the Physician Plaintiffs and the members of the Medical Association Plaintiffs, through the means alleged above, United Healthcare conspired, agreed and combined with the HIAA Group to fix and suppress the prices paid for the purchase of medical services provided to subscribers under group health plans in local markets throughout the United States by, *inter alia*, artificially reducing the amounts to be paid for out-

of-network services via the Ingenix Databases, thereby driving beneficiaries to obtain medical services from in-network physicians, over whom United Healthcare and the HIAA Group hold significant buying power in local markets to further suppress the prices they pay to in-network physicians. The resulting harm is that prices paid to all physicians are artificially suppressed and the practices of all physicians damaged through lost revenues and lost patients.

344. United Healthcare's and the HIAA Group's aforementioned exercise of buyer power in violation of § 1 of the Sherman Act entitles the Physician Plaintiffs and the Medical Association Plaintiffs to relief, pursuant to Sections 4 and 16 of the Clayton Act, including declaratory and injunctive relief.

COUNT XVI

VIOLATION OF SHERMAN ACT SECTION 1
(UCR Reimbursement and Medical Services Buyer Power)

345. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

346. The New York Union Plaintiffs have been harmed due to certain of their members suffering reduced UCR reimbursement amounts for charges related to out-of-network services to well below the market levels, thereby reducing such members' coverage and shifting the cost of charges that should have been covered on the backs of such members.

347. Through the means alleged above, United Healthcare conspired, agreed and combined with the HIAA Group to fix and suppress the prices paid for the purchase of medical services provided to subscribers under group health plans in local markets throughout the United States by artificially reducing the amounts to be paid for out-of-network services via the Ingenix Databases, thereby driving subscribers to obtain medical services from in-network physicians, over whom United Healthcare and the HIAA Group hold significant buying power in local

markets to further suppress the prices they pay to in-network physicians. The resulting harm is that subscribers are forced to either accept significant out-of-pocket expenses for obtaining out-of-network services or forego the benefit for which they have paid additional premiums and obtain services from in-network physicians.

348. United Healthcare has violated and continues to violate § 1 of the Sherman Act, for which the New York Union Plaintiffs are entitled to declaratory and injunctive relief to prevent further harm.

COUNT XVII

VIOLATION OF 18 U.S.C. § 1962(c)

349. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

350. The Class Plaintiffs, the Medical Association Plaintiffs, and the New York Union Plaintiffs bring this RICO Count against United Healthcare pursuant to 18 U.S.C. § 1962(c).

351. At all relevant times, United Healthcare was a "person" within the meaning of RICO, 18 U.S.C. §§ 1961(3) and 1964(c).

352. At all relevant times, United Healthcare carried out its false payment schemes in connection with an association-in-fact "enterprise," within the meaning of 18 U.S.C. § 1961(4) (the "Out-of-Network Reimbursement Enterprise" or "Enterprise"), comprised of itself, the users of its Ingenix Databases (including insurance companies who are members of the HIAA Group), United Healthcare and the entities whose insurance healthcare plans it administers either as a plan administrator or claims administrator.

353. At all relevant times, the Out-of-Network Reimbursement Enterprise was engaged in, and its activities affected, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c).

354. The Out-of-Network Reimbursement Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which United Healthcare has engaged. In addition to the Enterprise's legitimate and lawful activities, United Healthcare used the Enterprise's structure to carry out the fraudulent and unlawful activities set forth herein.

355. As set forth below, in violation of RICO, specifically, 18 U.S.C. § 1962(c), United Healthcare conducted and participated in the conduct of the Enterprise's affairs (specifically, through its participation in the operation and management of the Enterprise), directly and indirectly, through a "pattern of racketeering activity," as defined in 18 U.S.C. § 1961(5).

356. United Healthcare, through its officers, agents, employees and affiliates, has committed numerous predicate acts as defined in 18 U.S.C. § 1961(5) dating back to July 15, 2000 (and continues to commit such predicate acts) in furtherance of its false payment schemes with respect to reimbursement of claims for out-of-network charges, with such predicate acts including: (i) mail fraud in violation of 18 U.S.C. § 1341 and (ii) wire fraud in violation of 18 U.S.C. § 1343.

357. As previously set forth in greater detail herein, United Healthcare, acting through its officers, agents, employees and affiliates effectuating United Healthcare's corporate policies and procedures, committed numerous racketeering acts, with specific intent to commit such acts, as defined in 18 U.S.C. § 1961(5), including the following:

a) by mailing or causing to be mailed and otherwise knowingly agreeing to the mailing of various materials and information, including but not limited to falsified UCR determinations and EOBs, received or sent source data, modified and falsified data, software and other components of, or information utilized by PHCS, for the purpose of effectuating the above-described false payment schemes, with each such mailing constituting a separate and distinct violation of 18 U.S.C. § 1341; and

b) by transmitting or causing to be transmitted and otherwise knowingly agreeing to the transmittal of various materials and information, including but not limited to falsified UCR determinations and related explanation of such determinations, by means of telephone and facsimile, in interstate commerce, for the purpose of effectuating the above-described false payment schemes, and each such transmission constituting a separate and distinct violation of 18 U.S.C. § 1343.

358. As set forth above, United Healthcare concocted multiple schemes to make improperly reduced payments on claims for reimbursement of out-of-network charges.

359. In furtherance of its false payment schemes, United Healthcare, in violation of 18 U.S.C. §§ 1341 and 1343, repeatedly and regularly used the U.S. Mail and interstate wires to further all aspects of the false payment schemes by delivering and/or receiving materials, including plan documents, insurance policies, summary plan descriptions, certificates of coverage, claim forms, reimbursement checks, EOBs describing UCR fee determinations, appeal determinations, and other materials necessary to effectuate the false payment schemes, as well as to receive, comment upon, edit and manipulate the source data for the Ingenix Databases.

360. The foregoing mail communications and wire communications contained false and fraudulent misrepresentations and/or omissions of material facts, and/or otherwise were incident to an essential part of the false payment schemes and were used to provide the false payment schemes with an appearance of legitimacy and regularity, and/or postpone ultimate discovery and complaint of the false payment schemes, and thereby make the discovery of the false payment schemes less likely than if no such mailings or wire transmissions had taken place, and had the design and effect of preventing a meaningful evaluation and review of United Healthcare's UCR determinations.

361. The misrepresentations and omissions in these materials have included and include those set forth previously herein.

362. As named fiduciaries and claims administrators of various of the United Healthcare Plans, United Healthcare occupied and occupies a position of trust and it had, and has a special relationship with subscribers and their assignees and Class Plaintiffs that requires it to accurately represent the terms and conditions of the United Healthcare Plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

363. United Healthcare knew that subscribers and their assignees, and Class Plaintiffs would reasonably rely on the accuracy, completeness and integrity of United Healthcare's disclosures, and subscribers and their assignees and Class Plaintiffs did rely to their detriment on United Healthcare's misrepresentations and omissions.

364. Each such use of the U. S. Mails and interstate wires constitutes a separate and distinct predicate act.

365. The above-described acts of mail and wire fraud are related in that they each involved common participants, common methodologies, common results impacting upon common victims and a common purpose of executing the false payment schemes, and are continuous in that they occurred over a significant period of years, and constitute the usual practice of United Healthcare such that they amount to and pose a threat of continued racketeering activity.

366. The purpose of United Healthcare's false payment schemes was to underpay the guaranteed benefits to which subscribers and their assignees and members of the Class are contractually entitled, and convert those withheld funds for its own direct or indirect financial

gain, to profit from the licensing of the Ingenix Databases, which it marketed as a way to reduce UCR reimbursement costs, to create an appearance of regularity and legitimacy in reimbursement determinations through the provision of false and incomplete information provided to subscribers and their assignees and Class Plaintiffs, and to obtain revenue through its plan and claims administration business.

367. The direct and intended victims of the pattern of racketeering activity described previously herein are subscribers and their assignees and Class Plaintiffs, who United Healthcare has deprived or caused to be deprived of the complete guaranteed benefits to which they are entitled as reimbursement on claims for out-of-network charges.

368. Subscribers and their assignees and Class Plaintiffs were injured by reason of United Healthcare's RICO violations in that they directly and immediately were deprived of hundreds of millions of dollars or more in guaranteed benefits on their claims for reimbursement of out-of-network charges, as well as the knowledge necessary to challenge false and manipulative UCR determinations, and their injuries were proximately caused by the violation of 18 U.S.C. § 1962(c) in that these injuries were the foreseeable, direct, intended and natural consequence of United Healthcare's RICO violations (and commission of underlying predicate acts), and, but for United Healthcare's RICO violations (and commission of underlying predicate acts), subscribers and their assignees and Class Plaintiffs would not have suffered the injuries suffered by them.

369. As a result of its misconduct, United Healthcare is liable to subscribers, their assignees, and similarly situated class members in an amount to be determined at trial.

370. Pursuant to RICO, 18 U.S.C. § 1964(c), subscribers, their assignees, and Class Plaintiffs are entitled to recover threefold their damages, and costs and attorneys' fees, from

United Healthcare. In addition, subscribers, their assignees, Class Plaintiffs, the Medical Association Plaintiffs and the New York Union Plaintiffs are entitled to declaratory and injunctive relief to enjoin United Healthcare's ongoing racketeering.

COUNT XVIII
VIOLATION OF 18 U.S.C. § 1962(c)

371. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

372. The Class Plaintiffs (excluding the Empire Plan Plaintiffs) (hereinafter, the "664 Plaintiffs") bring this Count against United Healthcare pursuant to 18 U.S.C. § 1962(c).

373. At all relevant times, United Healthcare was a "person" within the meaning of RICO, 18 U.S.C. §§ 1961(3) and 1964(c).

374. At all relevant times, United Healthcare carried out its false payment schemes in connection with an "enterprise," within the meaning of 18 U.S.C. § 1961(4), namely, the previously defined Out-of-Network Reimbursement Enterprise comprised of itself, the users of the Ingenix Databases (including insurance companies who are members of the HIAA Group), United Healthcare Plans, and the entities whose group health plans it administered either as a plan administrator or claim administrator.

375. At all relevant times, the Out-of-Network Reimbursement Enterprise was engaged in, and its activities affected, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c).

376. The Out-of-Network Reimbursement Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which United Healthcare has engaged. In addition to the Enterprise's legitimate and lawful

activities, United Healthcare used the Enterprise's structure to carry out the fraudulent and unlawful activities set forth in this complaint.

377. As set forth below, in violation of RICO, specifically, 18 U.S.C. § 1962(c), United Healthcare conducted and participated in the conduct of the Enterprise's affairs (specifically, through its participation in the operation and management of such Enterprise), directly and indirectly, through a "pattern of racketeering activity," as defined in 18 U.S.C. § 1961(5).

378. United Healthcare, through its officers, agents, employees and affiliates, has committed numerous predicate acts as defined in 18 U.S.C. § 1961(5) dating back to July 15, 2000 (and continues to commit such predicate acts) in furtherance of its false payment schemes with respect to reimbursement of claims for out-of-network charges, with such predicate acts including (i) conversion of employee benefit plan assets in violation of 18 U.S.C. § 664, (ii) mail fraud in violation of 18 U.S.C. § 1341, and (iii) wire fraud in violation 18 U.S.C. § 1343.

379. As previously set forth in greater detail herein, United Healthcare, acting through its officers, agents, employees and affiliates effectuating United Healthcare's corporate policies and procedures, committed numerous racketeering acts, with specific intent to commit such acts, as defined in 18 U.S.C. § 1961(5), including the following:

a) converting plan funds specifically earmarked as guaranteed benefits for the Section 664 Plaintiffs and the Section 664 Class on each and every occasion upon which United Healthcare made or caused to be made a false payment on claims for reimbursement of out-of-network charges, with each false payment constituting a separate and distinct violation of 18 U.S.C. § 664;

b) by mailing or causing to be mailed and otherwise knowingly agreeing to the mailing of various materials and information, including but not limited to falsified UCR determinations and EOBs describing such determinations, received or sent source data, modified and falsified data, software and other components of or material or information utilized by PHCS, for the purpose of effectuating the above-described false payment schemes, with each such mailing constituting a separate and distinct violation of 18 U.S.C. § 1341; and

c) by transmitting or causing to be transmitted and otherwise knowingly agreeing to the transmittal of various materials and information, including but not limited to falsified UCR determinations and EOBs describing such determinations, by means of telephone and facsimile, in interstate commerce, for the purpose of effectuating the above-described false payment schemes, and each such transmission constituting a separate and distinct violation of 18 U.S.C. § 1343.

380. The RICO statute specifically identifies "any act which is indictable under . . . section 664 (relating to embezzlement from pension and welfare funds)" as a predicate act. 18 U.S.C. § 1961(1)(B). Section 664 of Title 18 provides:

> **Theft or embezzlement from employee benefit plan**
>
> Any person who embezzles, steals, or unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the moneys, funds, securities, premiums, credits, property, or other assets of any employee welfare benefit plan or employee pension benefit plan, or of any fund connected therewith, shall be fined under this title, or imprisoned not more than five years, or both.

381. Each of the United Healthcare Plans that is an "employee welfare benefit plan" within the meaning of 29 U.S.C. § 1002(1)(A), and otherwise is subject to "any provision of title I of the Employee Retirement Income Security Act of 1974," 29 U.S.C. § 1001 *et seq.* is included in this Count. Several such Plans are administered on behalf of American Airlines employees and retirees.

382. Each of the United Healthcare Plans that is subject to ERISA is fully funded by insurance coverage United Healthcare provides or administers. The applicable plan documents expressly state that all benefits due under the plan terms will be paid and that the underlying benefits they expressly guarantee are plan assets.

383. The 664 Plaintiffs, including subscribers and their assignees, are entitled to reimbursement on claims for out-of-network charges based on UCR amounts, and the governing plan documents warrant that all benefits due under the plans will be paid. By making improperly reduced payments on claims, United Healthcare intentionally caused the 664 Plaintiffs to be

underpaid guaranteed benefits to which they were entitled to in accordance with the terms of their group health plans. United Healthcare caused these funds to be withheld for its own financial gain, as well as profiting through the PHCS users' licensing of PHCS, and from the revenues generated from its administration (as either plan administrator or claim administrator) of certain of the United Healthcare Plans.

384. United Healthcare acted with specific intent to deprive the 664 Plaintiffs of guaranteed benefits, and was sufficiently aware of the facts to know that it was acting unlawfully and contrary to the trust placed in them by the 664 Plaintiffs and the insurers whose plans it was administering.

385. Each false payment on a claim constitutes a separate and distinct predicate act, in violation of 18 U.S.C. § 664, of converting or misappropriating funds specifically earmarked within the applicable plan as a guaranteed benefit for intended subscribers and their assignees, for United Healthcare's direct or indirect benefit.

386. As set forth above, United Healthcare concocted multiple schemes to make improperly reduced payments on claims for reimbursement of out-of-network charges.

387. In furtherance of its false payment schemes, United Healthcare, in violation of 18 U.S.C. §§ 1341 and 1343, repeatedly and regularly used the U.S. Mails and interstate wires to further all aspects of the false payment schemes by delivering and/or receiving materials, including plan documents, insurance policies, summary plan descriptions, certificates of coverage, claim forms, reimbursement checks, EOBs describing UCR fee determinations, appeal determinations, and other materials necessary to effectuate the false payment schemes, as well as to receive, comment upon, edit and manipulate the source data for the Ingenix Databases.

388. The foregoing mail communications and wire communications contained false and fraudulent misrepresentations and omissions of material facts, and otherwise were incident to an essential part of the false payment schemes and were used to provide the false payment schemes with an appearance of legitimacy and regularity, and postpone ultimate discovery and complaint of the false payment schemes, and thereby make the discovery of the false payment schemes less likely than if no such mailings or wire transmissions had taken place, and had the design and effect of preventing a meaningful evaluation and review of United Healthcare's UCR determinations.

389. As fiduciaries and claims administrators of various of the United Healthcare Plans, United Healthcare occupied and occupies a position of trust and it had, and has, a special relationship with the 664 Plaintiffs that requires it to accurately represent the terms and conditions of the United Healthcare Plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

390. United Healthcare knew that the 664 Plaintiffs would reasonably rely on the accuracy, completeness and integrity of United Healthcare's disclosures, and subscribers and their assignees did rely to their detriment on United Healthcare's misrepresentations and omissions.

391. Each such use of the U.S. Mail and interstate wires constitutes a separate and distinct predicate act.

392. The above-described acts of conversion of employee benefit plan funds, and mail and wire fraud, are related in that they each involved common participants, common methodologies, common results impacting upon common victims and a common purpose of executing the false payment schemes, and are continuous in that they occurred over a significant

period of years, and constitute the usual practice of United Healthcare such that they amount to and pose a threat of continued racketeering activity.

393. The purpose of United Healthcare's false payment schemes was to underpay the guaranteed benefits to which the 664 Plaintiffs are contractually entitled, and convert those withheld funds for its own direct or indirect financial gain, to profit from the licensing of PHCS, which it marketed as a way to reduce UCR reimbursement costs, to create an appearance of regularity and legitimacy in reimbursement determinations through the provision of false and incomplete information provided to subscribers and their assignees, and to obtain revenue through its plan and claims administration business.

394. The direct and intended victims of the pattern of racketeering activity described previously herein are subscribers and their assignees who United Healthcare has deprived or caused to be deprived of the guaranteed benefits to which they are entitled as reimbursement on claims for out-of-network charges.

395. United Healthcare's RICO violation injured the 664 Plaintiffs by depriving them of hundreds of millions of dollars in guaranteed benefits on their claims for reimbursement of out-of-network charges, as well as the knowledge necessary to challenge false and manipulative UCR determinations, and their injuries were proximately caused by the violation of 18 U.S.C. § 1962(c) in that these injuries were the foreseeable, direct, intended and natural consequence of United Healthcare's RICO violations (and commission of underlying predicate acts), and but for United Healthcare's RICO violations (and commission of underlying predicate acts), the 664 Plaintiffs would not have suffered the injuries suffered by them.

396. As a result of its misconduct, United Healthcare is liable to the 664 Plaintiffs.

397. Pursuant to RICO, 18 U.S.C. § 1964(c), the 664 Plaintiffs are entitled to injunctive and declaratory relief, and to recover threefold their damages, and costs and attorneys' fees from United Healthcare.

COUNT XIX
VIOLATION OF FLA. STATUTES, § 895.01 ET SEQ.

398. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

399. David Finley and Colleen Finley, individually and on behalf of the Florida RICO Subclass assert this Count for declaratory and injunctive relief against United Healthcare pursuant to the Florida RICO Act, § 895.01 *et seq.*

400. At all relevant times, United Healthcare was a "person" pursuant to Florida RICO Act, § 895.03.

401. At all relevant times, United Healthcare carried out its false payment schemes in connection with an association-in-fact "enterprise," within the meaning of the Fla. RICO Act, § 895.02(3), namely, the Out-of-Network Reimbursement Enterprise comprised of itself, the users of the Ingenix Databases (including insurance companies who are members of the HIAA Group), United Healthcare Plans, and the entities whose group health plans it administered either as a plan administrator or claim administrator. At all relevant times, the Out-of-Network Reimbursement Enterprise was engaged in, and its activities affected interstate commerce, including commerce within the state of Florida.

402. The Out-of-Network Reimbursement Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which United Healthcare has engaged. In addition to the Enterprise's legitimate and lawful

activities, United Healthcare used the Enterprise's structure to carry out the fraudulent and unlawful activities set forth in this complaint.

403. As set forth below, in violation of the Florida RICO Act, § 895.03(3), United Healthcare conducted and participated in the conduct of the Enterprise's affairs (specifically, through its participation in the operation and management of such Enterprise), directly and indirectly, through a "pattern of racketeering activity," as defined in Florida RICO Act, § 895.03(4).

404. United Healthcare, through its officers, agents, employees and affiliates, has committed numerous predicate acts of "racketeering activity," as defined in Florida RICO Act, § 895.02(1), and as defined in 18 U.S.C. § 1961(1) which is incorporated by reference into Florida RICO Act, § 895.02(1), dating back to July 15, 2000, and continues to commit such predicate acts, in furtherance of its false payment schemes with respect to reimbursement of claims for out-of-network charges, with such predicate acts including (i) conversion of employee benefit plan assets in violation of 18 U.S.C. § 664, (ii) mail fraud in violation of 18 U.S.C. § 1341; (iii) wire fraud in violation 18 U.S.C. § 1343; and (iv) commission of fraudulent practices in violation of Chapter 817 of Florida Statutes.

405. As previously set forth, United Healthcare, acting through its officers, agents, employees and affiliates, knowingly committed numerous and repeated racketeering acts of conversion of plan funds in violation of 18 U.S.C. § 664, mail fraud in violation of 18 U.S.C. § 1341, and wire fraud in violation of 18 U.S.C. § 1343, all with specific intent to commit such acts, such acts, together, constituting a pattern of racketeering as defined in the Florida RICO Act, 895.02(4).

406. As previously set forth, United Healthcare has engaged in and continues to engage in a scheme to defraud and obtain property thereby, in violation of Fla. Statute, § 817.034(4)(a), and, in furtherance of such scheme, has communicated with and continues to communicate with subscribers resident in Florida, each such communication constituting a violation of Fla. Statute § 817.034(4)(b).

407. The above-described acts of conversion of employee benefit plan funds, mail and wire fraud, and violations of Chapter 817 of Florida Statutes, were and are related in that they each involved common participants, common methodologies, common results impacting upon common victims and a common purpose of executing the false payment schemes, are continuous in that they occurred over a significant period of years, and constitute the usual practice of United Healthcare such that they amount to and pose a threat of continued racketeering activity.

408. The purpose of United Healthcare's false payment schemes was to underpay the guaranteed benefits to which the Florida RICO Subclass members were contractually entitled, and convert those withheld funds for its own direct or indirect financial gain, to profit from the licensing of PHCS, which it marketed as a way to reduce UCR reimbursement costs, to create an appearance of regularity and legitimacy in reimbursement determinations through the provision of false and incomplete information provided to the Florida RICO Subclass, and to obtain revenue through its plan and claims administration business.

409. The direct and intended victims of the pattern of racketeering activity described previously herein are the Finleys and the Florida RICO Subclass, subscribers residing in Florida, whom United Healthcare has deprived or caused to be deprived of the benefits to which they are entitled as reimbursement on claims for out-of-network charges.

410. The Finleys and the Florida RICO Subclass members were injured and are aggrieved by reason of United Healthcare's violation of Florida RICO in that they directly and immediately were deprived of millions of dollars in guaranteed benefits on their claims for reimbursement of out-of-network charges, as well as the knowledge necessary to challenge false and manipulative UCR determinations, and their injuries were proximately caused by the violation of the Florida RICO Act, § 895.03(3), in that those injuries were the foreseeable, direct, intended and natural consequence of United Healthcare's violation of Florida RICO (and commission of underlying predicate acts), and but for United Healthcare's violation of Florida RICO (and commission of underlying predicate acts), the Finleys and the Florida RICO Subclass members would not have suffered such injuries.

411. Pursuant to the Florida RICO Act, § 895.05(6), the Finleys and the Florida RICO Subclass members seek and are entitled to declaratory and injunctive relief.

PRAYER FOR RELIEF

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

A. Declaring that United Healthcare has failed to comply with the terms of its group plans, and awarding unpaid benefits to the Direct Insured Plaintiffs for all exhausted claims, and awarding injunctive and declaratory relief to them to enforce plan terms and to clarify future entitlement to benefits;

B. Declaring that United Healthcare has failed to comply with the terms of its group plans, and awarding unpaid benefits to Physician Plaintiffs for assigned claims which have been administratively exhausted, and for injunctive and declaratory relief to enforce the terms of the group health plans, and awarding prejudgment interest, costs, expenses, and attorneys' fees to the Physician Plaintiffs;

C. Declaring that United Healthcare breached its fiduciary duties of loyalty and care to the Subscriber Plaintiffs and awarding appropriate equitable and declaratory relief for such breaches, including removal of United Healthcare as a fiduciary;

D. Declaring that United Healthcare violated its disclosure obligations under 29 U.S.C. § 1024(b)(4), for which the Direct Insured Plaintiffs are entitled to remedies under 29 U.S.C. § 1132(c), and further declaring that United Healthcare violated its obligations under 29 U.S.C. § 1022, for which the Direct Insured Plaintiffs are entitled to injunctive and other equitable relief;

E. Declaring that United Healthcare violated its disclosure obligations, including under 29 U.S.C. § 1133, to disclose to the Direct Insured Plaintiffs the specific reasons and pertinent documents related to claim denials, and ordering declaratory and injunctive relief for Direct Insured Plaintiffs;

F. Declaring that United Healthcare committed a breach of co-fiduciary duty to the Self-Funded Plaintiffs under 29 U.S.C. § 1105, and that such Plaintiffs are entitled to declaratory and injunctive relief;

G. Declaring that United Healthcare violated claims procedures required under federal law, and ordering equitable relief, including declaratory and injunctive relief, for Subscriber Plaintiffs;

H. Preliminarily and permanently enjoining United Healthcare and all persons acting under, in concert with, or for it, from paying reduced UCR on the basis of invalid or inappropriate data;

I. Declaring that American Airlines failed to comply with the terms of its group plans, and awarding unpaid benefits to the American Airlines Plaintiffs for all claims that have

been administratively exhausted, and awarding injunctive and declaratory relief to American Airlines Plaintiffs to enforce plan terms and to clarify future entitlement to benefits;

J. Declaring that American Airlines breached its fiduciary duties of loyalty and care to the American Airlines Plaintiffs, and awarding appropriate relief and declaratory and injunctive relief to such plaintiffs;

K. Declaring that American Airlines violated its obligations under 29 U.S.C. § 1024(b)(4), for which the American Airlines Plaintiffs are entitled to remedies under 29 U.S.C. § 1132(c), and further declaring that American Airlines violated its obligations under 29 U.S.C. § 1022, for which the American Airlines Plaintiffs are entitled to injunctive and other equitable relief;

L. Declaring that American Airlines violated its disclosure obligations, including under 29 U.S.C. § 1133, to disclose to the American Airlines Plaintiffs the specific reasons and pertinent documents related to claim denials, and ordering declaratory and injunctive relief to such plaintiffs;

M. Declaring that United Healthcare and Met Life breached their duties under the Empire Plan, and providing compensatory damages to the Empire Plan Plaintiffs, along with declaratory and injunctive relief to the Empire Plan Plaintiffs and the New York Union Plaintiffs necessary to remedy such breach of contract;

N. Awarding the Empire Plan Plaintiffs compensatory damages, and awarding the Empire Plan Plaintiffs and the New York Union Plaintiffs declaratory and injunctive relief to remedy United Healthcare and Met Life's deceptive practices;

O. Preliminarily and permanently enjoining United Healthcare from continuing to promote and sell the Ingenix Databases as a means for determining UCR amounts;

P. Declaring that United Healthcare engaged in a restraint of trade to cause the UCR reimbursement amounts paid to the Class Plaintiffs for out-of-network services to be reduced below market levels, thereby raising the costs of such out-of-network services for subscribers and reducing the level of medical services available to subscribers who obtain coverage from group health plans in violation of the Sherman Act, 15 U.S.C. §1;

Q. Awarding the Class Plaintiffs compensatory damages and consequential damages, trebled as required by law, plus attorneys fees and costs, pursuant to Section 4 of the Clayton Act, 15 U.S.C. §15(a) for United Healthcare's violation of Section 1 of the Sherman Act and such other and additional relief as is just and proper;

R. Preliminarily and permanently enjoining United Healthcare and all persons acting under, in concert with, or for it, from (i) paying reduced UCR by using the Ingenix Databases, or (ii) otherwise violating RICO, or committing acts of conversion of plan funds in violation of 18 U.S.C. § 664, mail fraud in violation of 18 U.S.C. § 1341, and wire fraud in violation of 18 U.S.C. § 1343, in connection with, directly or indirectly, United Healthcare's ownership, management, sale, license, application and/or use of the Ingenix Databases; and granting such other and further relief as is just and proper;

S. Awarding judgment against United Healthcare and in favor of all Class Plaintiffs for compensatory damages, treble damages and attorneys' fees and costs for violation of RICO;

T. Awarding the Physician Plaintiffs compensatory damages, treble damages, attorneys' fees and costs in connection with injuries incurred by them by reason of United Healthcare's RICO violations;

U. Awarding the Florida RICO Plaintiffs judgment against United Healthcare preliminarily and permanently enjoining United Healthcare and all persons acting under, in

concert with, or for it, from (i) paying less than the stated percentage of out-of-network providers' actual charges by means of using the Ingenix Databases, or (ii) otherwise violating Florida RICO Act, in connection with, directly or indirectly, United Healthcare's ownership, management, sale, license, application and/or use of falsified Ingenix Databases; and granting such other and further relief as is just and proper;

V. Awarding prejudgment interest and all other interest permitted by law;

W. Awarding all Plaintiffs and the Class the costs and disbursements of this action, including reasonable counsel fees, costs and reimbursements of expenses including expert fees in amounts to be determined by the Court; and

W. Awarding such other and further relief as the Court may deem to be just and proper.

DEMAND FOR A TRIAL BY JURY

Plaintiffs hereby demand a trial by jury on all claims so triable.

Dated: July 10, 2007

Respectfully submitted,

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE AMERICAN MEDICAL ASSOCIATION, et al.,	:	
Plaintiffs,	:	Case No. 00 Civ. 2800 (LMM)(GWG)
-against-	:	
UNITED HEALTHCARE CORPORATION, et al.,	:	
Defendants.	:	

I, Susan J. Weiswasser, an attorney duly admitted to practice before this Court, certify that on July 11, 2007, I caused to be served the foregoing Fourth Amended Complaint by hand delivery upon:

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