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**UNITED STATES DISTRICT COURT  
DISTRICT OF NEW JERSEY**

AMERICAN MEDICAL ASSOCIATION,  
MEDICAL SOCIETY OF NEW JERSEY,  
MEDICAL SOCIETY OF THE STATE OF  
NEW YORK, CONNECTICUT STATE  
MEDICAL SOCIETY, TEXAS MEDICAL  
ASSOCIATION, and NORTH CAROLINA  
MEDICAL SOCIETY, and JAMES N.  
GARDNER, M.D. and DARRICK E. ANTELL  
M.D., Individually And On Behalf of All Others  
Similarly Situated,

Plaintiffs,

vs.

CONNECTICUT GENERAL LIFE  
INSURANCE CO., CIGNA CORPORATION,  
and CIGNA HEALTH CORPORATION,

Defendants.

Civil Action No. 09-578(FSH)

**CORRECTED COMPLAINT and  
DEMAND FOR JURY TRIAL**

Plaintiffs James N. Gardner, M.D. and Darrick E. Antell, M.D. (the “Individual Plaintiffs”) bring this action on behalf of themselves and all others similarly situated, and Plaintiffs American Medical Association (“AMA”), Medical Society of New Jersey (“MSNJ”), Medical Society of the State of New York (“MSSNY”), Connecticut State Medical Society (“CSMS”), Texas Medical Association (“TMA”), and North Carolina Medical Society (“NCMS”) (collectively the “Associational Plaintiffs”) bring this action on behalf of themselves and on behalf of their membership by way of Complaint against Defendants Connecticut General Life Insurance Company, Cigna Corporation and Cigna Health Corporation’s (collectively, “CIGNA” or “Defendants”), say:

#### **SUMMARY OF CLAIMS**

1. The Individual Plaintiffs bring this case as a class action on behalf of themselves and all those similarly situated physicians and physician groups (the “Class”)<sup>1</sup> who are, or have been nonparticipating, or “out-of-network,” providers (“Nonpars” or “Non-participating” physicians or providers), in that they have not been members in CIGNA’s physicians networks during the period from January 1, 2005 through the present (the “Class Period”), alleging violations of the Employee Retirement Insurance Security Act of 1974 (“ERISA”), the Racketeer Influenced and Corrupt Organizations Act (“RICO”), and the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq.*, as described herein. As Nonpars in CIGNA’s physicians’ networks, the Individual Plaintiffs and the Class have been harmed by underpayments made by CIGNA for out-of-network services that they provided to plan enrollees. These underpayments are pervasive and result from systematic operating procedures employed by CIGNA, which affect thousands of Nonpars every year.

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<sup>1</sup> References made to the “Class” encompass the RICO-Antitrust Class and the ERISA Sub-Class, as defined in paragraphs 140-41.

2. The Associational Plaintiffs bring this case on their own behalf and on behalf of their membership of physicians. The Associational Plaintiffs are dedicated to advocating for the rights of physicians and patients alike for the delivery of the highest quality of medical care. The Associational Plaintiffs have been directly injured by the egregious acts and practices of CIGNA as set forth in this Complaint. As a result of CIGNA's unlawful practices, the Associational Plaintiffs have been required to devote substantial time and resources counseling their members on how to deal with the practices at issue, monitoring the payment practices of CIGNA, corresponding with CIGNA, advocating on their members' behalf, and communicating with regulators concerning CIGNA's misconduct, among other things. Accordingly, the Associational Plaintiffs allege violations of ERISA on behalf of their membership, and violations of RICO and the Sherman Act, on behalf of themselves and their membership, against CIGNA as set forth below.

3. The Individual Plaintiffs and the Associational Plaintiffs are collectively referred to herein as "Plaintiffs."

4. Participating, or in-network providers ("Pars") are physicians who have signed a contract with a particular managed care entity and receive reimbursement of eligible charges directly from that entity. Pars agree to provide healthcare services to plan enrollees at reduced rates in exchange for access to the plan's patient base, among other things. When visiting a Par, plan members are only responsible for co-payments, co-insurance, and payment for non-covered items (if any) at the time of service.

5. Nonpars, by contrast, do not have a signed contract with a particular managed care entity. Nonpars, therefore, may collect their full charges directly from patients at the time of service and are not required to accept reduced rates for procedures performed. Rather than require plan members to pay out of pocket and in full for medical services, Nonpars may also agree to accept an assignment of benefits, which occurs when a plan member authorizes his

health benefits plan to remit payment directly to the provider for covered services. Managed care entities may refuse to recognize the patient's assignment and still remit payment to the patient. Whether or not the health plan honors the assignment and pays the out-of-network benefit amount to the physician, Nonpars are entitled to bill the patient for the amount of the physician's charge which exceeds the amount the health plan covers.

6. CIGNA contractually promises its members that it will pay for services performed by Nonpars at the lesser of the billed charge or the usual, customary and reasonable ("UCR," also known as "U&C" and "R&C") amount for the service rendered. CIGNA also contractually promises its members that the UCR rate for a service is the "prevailing charge" charged by most providers of comparable services in the specific area where the member received the service, with consideration given to the nature and severity of the member's condition, as well as any complications or unusual circumstances that would require additional time, skill, or experience on the part of the Nonpar.

7. During the Class Period, CIGNA typically used a database that it licensed from a third-party, Ingenix, Inc. ("Ingenix"), to price claims for reimbursement submitted by Nonpars. The Ingenix database, however, fails to comply with the definition of UCR contained in CIGNA's insurance contracts, and instead has been used by CIGNA as a tool to deny, delay, and impede lawful reimbursement to Nonpars. As a result, Nonpars like the Individual Plaintiffs and the Class, and many members of the Associational Plaintiffs have been forced to expend significant time and resources appealing improper UCR determinations and negotiating with CIGNA for their lawful reimbursement. CIGNA's wrongful conduct also frustrated the purpose of the Associational Plaintiffs, causing them to exhaust significant time and resources advocating on behalf of their members' rights.

8. CIGNA also failed to disclose critical facts about Ingenix data that CIGNA used to make out-of-network reimbursement decisions. Although CIGNA was aware of serious, systemic flaws in the Ingenix database, CIGNA concealed these flaws in its communications to Nonpars. The Ingenix database, for example, averages charges from both physicians and other healthcare providers that are not medical doctors. It also fails to consider provider, patient, and procedure specific factors affecting charges. These known flaws, among others like the use of outdated data, were deliberately used by CIGNA to diminish reimbursement to Nonpars. The non-disclosure of these material facts prevented Nonpars like the Individual Plaintiffs and the Class from effectively challenging or appealing CIGNA's improper UCR determinations.

9. During the Class period, CIGNA used other faulty methods for determining UCR when Ingenix data was unavailable. For example, in the absence of Ingenix data, CIGNA used what it calls a "behind-the-scenes program" to calculate UCR rates. CIGNA's "behind-the-scenes program" averaged charge data from all zip codes with a minimal amount of data for that Current Procedural Terminology ("CPT") code, and then priced UCR with a secret, undisclosed formula which did not comply with plan members' contracts with CIGNA, and was known only to CIGNA.

10. Whether it used Ingenix data, outdated Ingenix data, its own "behind-the-scenes program," or some other methodology to price UCR for Nonpars, CIGNA routinely and systematically underpaid Nonpars who submitted claims for reimbursement for out-of-network services.

11. In addition to using improper methodologies for deriving UCR rates, Plaintiffs and the Class challenge other Nonpar benefit reimbursement reductions, including those imposed by use of the following methods: use of discounted amounts or Par fee schedules; use of the average wholesale price ("AWP") to determine UCR for pharmaceutical drugs; failing to

properly credit deductible amounts and out-of-pocket maximums; failing to provide an appropriate appeals process mechanism; approving requests for preauthorization without disclosing its nonpayment of a large percentage of the billed charges; refusing to pay for facility fees for the proper use of accredited office based surgical (“OBS”) facilities, misapplying Par policies such as multiple procedure reductions to Nonpar claims, among other improper practices.

12. CIGNA’s deceitful and pervasive business practices forced Plaintiffs and the Class to expend significant time and resources towards identifying, disputing and then appealing CIGNA’s improper reimbursement determinations, oftentimes still resulting in underpayment. CIGNA’s Nonpar pricing methods violated CIGNA’s legal obligations to the Individual Plaintiffs and the Class, as assignees and beneficiaries of their patients’ benefits, and violated federal and state law as herein described, causing Plaintiffs and the Class significant financial harm.

#### **JURISDICTION AND VENUE**

13. Subject matter jurisdiction exists under both 28 U.S.C. § 1331 and §1332(d). The Individual Plaintiffs seek to represent all those similarly situated physicians and physicians’ groups as set forth in the Class definition stated in Paragraphs 140-41 of this Complaint.

14. Venue is appropriately established in this District under 28 U.S.C. § 1391, and § 1965 of RICO, 18 U.S.C. § 1965, because CIGNA conducts a substantial amount of business in this District and insures and administers health plans both inside and outside of this District. Venue is also appropriate in this District because Dr. Gardner is a New Jersey state resident and practices medicine in New Jersey and much of the conduct described below occurred in New Jersey. Likewise, MSNJ is a citizen of New Jersey and represents physicians licensed to practice medicine in New Jersey.

15. This Complaint is also filed as related to existing litigation pending in this District. Namely, *Wachtel v. Health Net, Inc. et al.*, Case No. 01-CV-4183 (FSH) (PS); *McCoy v. Health Net, Inc. et al.*, Case No. 03-CV-1801 (FSH) (PS); *Franco v. Connecticut General Life Insurance Co. et al.*, Case No. 04-CV-1318 (FSH) (PS); *Scharfman v. Health Net, Inc.*, Case No. 05-CV-0301 (FSH) (PS); and *Cooper v. Aetna Health, Inc., PA Corp.*, Case No. 07-cv-3541 (FSH) (PS).

## **PARTIES**

### **Individual Plaintiffs**

16. Plaintiff **Dr. James N. Gardner** is a plastic surgeon specializing in breast reconstruction surgery for cancer patients. Dr. Gardner is a citizen of the State of New Jersey and is licensed to practice medicine in New Jersey. He is also the Chairman of the Plastic Surgery Department at Overlook Hospital and works in private practice at Summit Plastic Surgery, in New Jersey. Dr. Gardner is a Nonpar in CIGNA's physicians networks.

17. Plaintiff **Dr. Darrick E. Antell** is a board certified plastic and reconstructive surgeon who has been in practice for over 20 years. He is an official spokesperson for the American Society of Plastic Surgeons and is a Fellow of the American College of Surgeons. He received his general surgery training at Stanford University Medical Center and his specialty training in plastic/reconstructive surgery at the New York Hospital/Cornell Medical Center and the Memorial Sloan-Kettering Cancer Center in New York City. He also has a Doctor of Medical Dentistry degree from Case Western Reserve University. Dr. Antell is a citizen of the state of Connecticut and is licensed to practice medicine in New York, and he is a Nonpar in CIGNA's physician networks.

### **The Associational Plaintiffs**

18. 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 Jersey 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 payors, such as CIGNA, to healthcare providers, particularly physicians. Both AMA physicians and AMA in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

19. AMA appears herein on behalf of itself and its members, and also as a representative of the Litigation Center of the AMA and 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.

20. AMA has individual standing as it has been injured by CIGNA’s wrongful conduct as alleged herein. AMA has expended considerable time and resources helping its members deal with issues concerning CIGNA’s improper UCR reimbursements.

21. AMA also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit AMA seeks declaratory and injunctive relief.

22. Plaintiff **Medical Society of New Jersey (“MSNJ”)** is a New Jersey not-for-profit corporation organized and existing under the laws of New Jersey. MSNJ was founded in 1766, and is the oldest professional society in the United States. MSNJ represents approximately 8,000 physicians in the State of New Jersey. The organization and its dues-paying members are

dedicated to a healthy New Jersey, working to ensure the sanctity of the physician–patient relationship. In representing all medical disciplines, MSNJ advocates for the rights of patients and physicians alike, for the delivery of the highest quality medical care. This allows response to the patients’ individual, varied needs, in an ethical and compassionate environment, in order to create a healthy New Jersey and healthy citizens. MSNJ’s stated mission is “[t]o promote the betterment of the public health and the science and the art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.” Both MSNJ physicians and MSNJ in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

23. MSNJ has individual standing as it has been injured by CIGNA’s wrongful conduct as alleged herein. MSNJ has expended considerable time and resources helping its members deal with issues concerning CIGNA’s improper UCR reimbursements.

24. MSNJ also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit MSNJ seeks declaratory and injunctive relief.

25. Plaintiff **Medical Society of the State of New York** (“MSSNY”) is a New York not-for-profit corporation organized and existing under the laws of the State of New York since 1807. MSSNY represents approximately 30,000 licensed physicians, medical residents, and medical students in New York State. MSSNY is committed to representing the medical profession as a whole and advocating health related rights, responsibilities and issues. MSSNY is further committed to serving as a resource for its members and assisting them in addressing the many issues and needs which they face in providing health care to their patients. MSSNY strives to enhance the delivery of medical care of high quality to all people in the most economical

manner, and to act to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public. Both MSSNY physicians and MSSNY in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

26. MSSNY has individual standing as it has been injured by CIGNA's wrongful conduct as alleged herein. MSSNY has expended considerable time and resources helping its members deal with issues concerning CIGNA's improper UCR reimbursements.

27. MSSNY also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit MSSNY seeks declaratory and injunctive relief.

28. Plaintiff **Connecticut State Medical Society ("CSMS")** is a federation of eight component county medical associations, with a total membership exceeding 7,000 physicians and medical students. CSMS itself is a constituent state entity of the American Medical Association. Founded by the physician-patriots of the American Revolution, the Society operates from a heritage of democratic principles embodied in its Charter and Bylaws. The philosophy and purpose of the CSMS is to promote the highest standards of medical care in the State of Connecticut, to work to preserve the integrity and independence of physicians, and to support the sanctity of the physician-patient relationship for the benefit of the public by, among other things, facilitating and assisting its physicians in providing top quality care to their patients, providing them with a unified voice and enabling them to take concerted action on behalf of their profession and of their patients, and acting and advocating on their behalf to preserve the ability, independence and freedom of physicians to render the best possible care to every patient. Both

CSMS physicians and CSMS in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

29. CSMS has individual standing as it has been injured by CIGNA's wrongful conduct as alleged herein. CSMS has expended considerable time and resources helping its members deal with issues concerning CIGNA's improper UCR reimbursements.

30. CSMS also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit CSMS seeks declaratory and injunctive relief.

31. Plaintiff **Texas Medical Association ("TMA")** was organized by 35 physicians in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. Today, with more than 43,000 physician and medical student members, TMA's vision is still to "improve the health of all Texans." TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients. TMA has four main goals: to protect, improve, and strengthen the viability of medical practices in Texas; to ensure continued success in legislative, regulatory, and legal interventions to enhance the statewide environment in which Texas physicians practice medicine; to strengthen physicians' trusted leadership role within their communities; and to enhance the powerful, effective, and unified voice of Texas medicine. Both TMA physicians and TMA in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

32. TMA has individual standing as it has been injured by CIGNA's wrongful conduct as alleged herein. TMA has expended considerable time and resources helping its members deal with issues concerning CIGNA's improper UCR reimbursements.

33. TMA also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit TMA seeks declaratory and injunctive relief.

34. Plaintiff **North Carolina Medical Society (“NCMS”)** is a North Carolina not-for-profit corporation organized and existing under the laws of North Carolina since 1849, with its headquarters located in Raleigh, North Carolina. NCMS represents over 11,000 members in North Carolina, including licensed physicians, physician assistants, medical interns and residents, medical students and retired physicians.

35. The philosophy and purpose of NCMS is to promote medical science, medical knowledge, and the highest standards of medical care in North Carolina. NCMS strives to enhance access to medical care of high quality to all people in North Carolina and to promote high standards in the practice of medicine in an effort to ensure that quality medical care is available to the public by *inter alia*, promoting competence in the art of medical practice, making the medical profession more useful to the public in the prevention and care of disease and improving the quality of life. NCMS is the largest physician organization in North Carolina. NCMS unifies doctors across North Carolina in all specialties and work settings on issues related to, *inter alia*: the physician-patient relationship, health and insurance regulation, and patient safety. NCMS devotes significant resources to advocating physician viewpoints in the public policy arena. Specifically, NCMS and its member physicians take an active role in issues raised by private companies, institutions, administrative agencies and the North Carolina General Assembly and work to assure that the views of the medical community are presented in an organized and effective fashion.

36. NCMS has individual standing as it has been injured by CIGNA's wrongful conduct as alleged herein. NCMS has expended considerable time and resources helping its members deal with issues concerning CIGNA's improper UCR reimbursements.

37. NCMS also has associational standing on behalf of its members who have claims against CIGNA for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit NCMS seeks declaratory and injunctive relief.

38. Plaintiffs AMA, MSNJ, MSSNY, CSMS, TMA, and NCMS are collectively referred to herein as the "Associational Plaintiffs."

39. The Individual Plaintiffs and the Associational Plaintiffs are collectively referred to herein as "Plaintiffs."

### **Defendants**

40. Defendant **Connecticut General Life Insurance Co.** is a Connecticut company with its principal place of business located in Bloomfield, Connecticut.

41. Defendant, **CIGNA Corporation** is incorporated in Delaware with its principal place of business located in Philadelphia, Pennsylvania.

42. Defendant, **CIGNA Health Corporation** is incorporated in Connecticut with its principal place of business located in Bloomfield, Connecticut.

43. Defendants Connecticut General Life Insurance Co., CIGNA Corporation, and, CIGNA Health Corporation are collectively referred to herein as "CIGNA" or "Defendants."

44. CIGNA is a managed care company that provides health insurance and related benefits to insureds through physicians and other providers such as hospitals. CIGNA reimburses physicians for services performed on plan enrollees. CIGNA's Explanation of Benefit ("EOB") records, Remittance Advices, and other official communications name

Connecticut General Life Insurance Company as the responsible entity while other communications name "CIGNA" or "CIGNA Health Care."

**UNDERSTANDING PARTICIPATING VERSUS  
NON-PARTICIPATING PHYSICIAN SERVICES**

45. Providers can either enter into an agreement with CIGNA or they can provide services to CIGNA's subscribers without any contract with CIGNA governing that relationship.

46. Where medical services are provided by a physician who has contracted with CIGNA or one of its competitors, the total reimbursement is a fee for service payment based upon the contractually agreed fee schedule normally attached to the provider contract. In this instance, the subscriber will usually pay a co-payment or some percentage of the charge based upon the subscriber's agreement with CIGNA, the particular service rendered, and the particular plan enrollment.

47. Where medical services are provided by a physician who has not contracted with CIGNA, no specific reimbursement rate has been agreed to by the provider and the provider may charge whatever he or she chooses. While a Nonpar may bill the retail costs of its procedures, CIGNA does not necessarily pay the total amount billed. Rather, CIGNA pays on a fee for service basis that is determined as the lesser of the provider's billed charges or a percentage of the usual, customary and reasonable amount as determined by CIGNA.

48. The UCR amount is the maximum amount the insurer will consider eligible for reimbursement to Nonpars who are outside of their network. UCR is supposedly determined based on a review of the prevailing charges made by peer physicians for a particular medical or health service by a specific type of physician within a specific community or geographical area. However, UCR is typically set by CIGNA and other insurance carriers using various internal and external data sources. The most common data source utilized to determine UCR is the Ingenix database.

**THE INGENIX DATABASE**

49. Ingenix data cannot accurately or properly determine UCR. Nevertheless, upon information and belief, at all relevant times Defendant CIGNA relied upon and utilized the Ingenix database to make UCR determinations. The Ingenix database includes two related databases which are based on the identical underlying data, known as the Prevailing Healthcare Charges System (“PHCS”) and Medical Data Research (“MDR”). Indeed, from 1998 through the present, CIGNA contributed claims data to Ingenix and received a discount on the purchase of the Ingenix database in return.

50. In December 1997, Ingenix purchased Medicode, Inc., a Salt Lake City-based provider of healthcare products, including MDR. In October 1998, Ingenix, a wholly-owned subsidiary of UnitedHealthCare, purchased a UCR database, PHCS, from the Health Insurance Association of America (“HIAA”), an insurance trade association.

51. Since 1973, HIAA had produced and marketed its database primarily to insurers, such as CIGNA. However, HIAA informed the data purchasers (including CIGNA) that it was not endorsing, approving, or recommending the use of any of its data for any particular purpose. In fact, HIAA released its data with a disclaimer that specifically stated, in relevant part, that the data was being provided to members [*i.e.*, companies such as CIGNA] for informational purposes only. The HIAA disclaimed any endorsement, approval or recommendation of the data, or its use to determine “usual and customary” charges.

52. Once Ingenix acquired PHCS from HIAA in 1998, it continued to use substantially the same disclaimer in its communications with insurers including CIGNA.

53. Nevertheless, throughout the Class Period, CIGNA used (and continues to use) the Ingenix data as the primary source of data upon which it bases its UCR determinations, even though CIGNA knows that the data cannot and should not be used for that purpose. CIGNA is

fully aware that the Ingenix database is not properly designed to determine UCR reimbursement amounts.

54. Moreover, CIGNA and Ingenix have both defended Ingenix data when questioned about UCR determinations made based on the database. By agreement, CIGNA relied on Ingenix to provide detailed “support” so it could defend its use of Ingenix data. Ingenix promised to supply witnesses in court in the event CIGNA’s use of the Ingenix data was ever challenged. Ingenix also provided graphs and other details, vouching for the accuracy and legitimacy of its data in the course of appeals and responding to questions posed to CIGNA. CIGNA in turn used these materials to vouch for its use of Ingenix data to those who questioned its UCR determinations.

55. There are a number of inherent flaws in the Ingenix data which makes it an invalid and inappropriate basis for setting UCR rates. Among other flaws, the Ingenix database:

- (a) Does not determine the numbers or types of providers in any geographic area;
- (b) Does not determine the actual types of procedures within a geographic area;
- (c) Collects charge data which is not representative of the actual number of procedures performed within a geographic area;
- (d) Does not collect sufficient data to enable its users to determine whether the data reflects the charges of providers with any particular degree of expertise or specialization;
- (e) Does not collect sufficient provider-specific data to enable its users to determine whether the charges are from one provider, from several providers, or from only a minority or specific subset of the providers in a geographic area;
- (f) Fails to compare providers of the same or similar training and experience level and, instead, combines and averages all provider charges by procedure code without even separating the charges of physicians and non-physicians;

(g) Does not collect patient specific information such as age or medical history or condition;

(h) Does not ascertain the most common charge for the same service or comparable service or supply;

(i) Does not determine the place of service or type of facility;

(j) Does not collect sufficient data to enable it or its users to determine an appropriate medical market for comparing like charges;

(k) Combines zip codes inappropriately, and uses zip codes instead of appropriate medical markets;

(l) Fails to compare procedures that use the same or similar resources (and other costs) to the provider but, rather, indiscriminately combines all provider charges by procedure code without regard to such factors;

(m) Fails to compare procedures of the same or similar complexity by, among other things, failing to record or account for CPT code modifiers;

(n) Does not use an appropriate statistical methodology;

(o) Does not properly consider charging protocols and billing practices generally accepted by the medical community or specialty groups;

(p) Does not properly consider medical costs in setting geographic areas;

(q) Lacks quality control, such as basic auditing, to ensure the validity, completeness, representativeness, and authenticity of the data submitted;

(r) Is subject to pre-editing by data contributors;

(s) Reports charges that are systemically skewed downward;

(t) Uses relative values and conversion factors to derive inappropriate UCR amounts;

(u) Uses a methodology that does not comply with CIGNA's contractual definition of UCR; and

(v) Purports to be confidential and/or proprietary, which prevents access to, and scrutiny of, the data by members or their employers.

56. These and other flaws render CIGNA's use of Ingenix data invalid and unlawful for determining UCR. By systematically and typically making UCR determinations without compliant and valid data to substantiate its determinations, CIGNA has breached its obligation to reimburse the Individual Plaintiffs and the Class for out-of-network services. Accordingly, all past UCR determinations based on Ingenix's noncompliant data should be overturned.

57. In a separate investigation into the flawed Ingenix database conducted by the New York Attorney General, Andrew Cuomo, Mr. Cuomo concluded that "the Ingenix databases in fact under-reimburse consumers." January 13, 2009 New York Attorney General Health Care Report "THE CONSUMER REIMBURSEMENT SYSTEM IS CODE BLUE" available at: [http://www.oag.state.ny.us/bureaus/health\\_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf](http://www.oag.state.ny.us/bureaus/health_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf)

58. According to Mr. Cuomo's report, an analysis of the New York market showed that insurers that used Ingenix and other similar methods to determine UCR "systematically under-reimburse New Yorkers for doctor's office visits." *Id.*

59. "When extrapolated across the State and the country, it is fair to say that the Ingenix databases have caused Americans to be under-reimbursed to the tune of at least hundreds of millions of dollars over the past ten years." *Id.* Physicians like the Individual Plaintiffs, the Class and members of the Associational Plaintiffs, of course, are primary victims of this under reimbursement scheme.

60. Moreover, the Individual Plaintiffs and the Class have also been disparaged by the pervasive under-reimbursement scheme, and their physician–patient relationships have been disrupted. According to Mr. Cuomo: “The responsible consumer reads the plan documents and sees a thicket of words. One term seems intelligible: the “usual and customary rate” of a similar physician for a similar service in a similar area. That sounds reasonable. The consumer makes the leap out-of-network and submits the bill to the insurer, only to be told the consumer will not be fully reimbursed because the doctor’s charge exceeded the usual and customary rate. The fog of ignorance continues, thanks to the insurer. The physician-patient relationship is undermined, as the physician has been branded a charlatan whose bills are inflated. No one’s interests here are advanced, except perhaps when next time, the consumer decides to stay in network for fear of what bills may accrue for out-of-network care. The interests advanced in that event are those of the insurer, whether by accident or design.” *Id.* In addition to the negative impact that this disparagement has had on Nonpars like the Individual Plaintiffs and the Class, the disruption of the patient-doctor relationship has significantly harmed the Associational Plaintiffs, which seek to safeguard this relationship.

61. In discussing where the blame for this under-reimbursement scheme should lie, the New York Attorney General explained: “[T]he fault cannot be laid on Ingenix alone. All industry members have benefited unfairly at the expense of consumers over the past ten years, and they continue to benefit unfairly from a rigged system day after day.” *Id.* CIGNA, as a significant beneficiary of the Ingenix database, should therefore be held accountable for its use of the database to under-reimburse the Individual Plaintiffs and the Class.

62. Simultaneous with the release of the New York Attorney General’s findings, UnitedHealthcare, the owner of the Ingenix database, settled claims centering on the Ingenix database and UCR reimbursements with the New York Attorney General and the AMA, among

others. As part of the New York Attorney General settlement, UnitedHealthcare agreed to pay the New York Attorney General approximately \$50 million dollars. These funds are earmarked for the creation of an independent non-profit organization, which will own and operate a new database to be used for UCR determinations. This new database will be designed to take the place of the UnitedHealthcare-owned Ingenix database.

63. Aetna also settled similar claims with the New York Attorney General for \$20 million. According to the announcement made by Aetna, Aetna pledged that it will stop using the Ingenix database for reimbursement purposes. The \$20 million will be used to help establish the independent database intended to replace the Ingenix database. Under the settlement, an additional \$60,000 will be paid by Aetna to cover the cost of the New York Attorney General's investigation of the company.

64. Furthermore, UnitedHealthcare also agreed to the terms of a settlement with a class of consumers and providers, the AMA, MSSNY and others, including the payment of approximately \$350 million to settle claims, similar to those alleged in this case, related to the underpayment of reimbursement amounts for out-of-network medical services.

65. Upon information and belief, CIGNA remains under investigation by the New York Attorney General for similar conduct.

**CIGNA UNDERTOOK OTHER ACTIONS  
DESIGNED TO DEPRESS THE AMOUNTS PAID  
FOR UCR BEYOND THE INGENIX DATABASE**

66. As a further means of reducing out-of-network reimbursement to Nonpars, CIGNA knowingly used outdated Ingenix data, which it internally referred to as "old" data, to price Nonpar claims during the Class Period.

67. CIGNA sometimes did not use the Ingenix data if that data did not report a certain number of charges for a given CPT code. Instead, each CIGNA claims platform applied its own

standard to determine the number of charges in the Ingenix data which would trigger the use of its default formula. On occasion, the platforms utilized out of date data and even more flawed than ordinary Ingenix data to determine the UCR amount.

68. Whenever the Ingenix data did not provide the minimum number of data points, CIGNA's claim systems applied CIGNA's own "default" formulas to calculate the UCR during the Class Period.

69. CIGNA did not disclose that "default" formulas were used to price UCR during the Class Period. Indeed, CIGNA members as well as Plaintiffs and the Class had no way of knowing that a "default" formula had been used to price UCR, nor the method inherent in such default formula.

70. CIGNA referred to one of its default formulas as a "behind-the-scenes" program. In September 2001, CIGNA personnel described a "behind-the-scenes" program to calculate UCR as follows:

Yes, you can say that if we receive less than 10 reportings [charges] on a SURGICAL procedure, a behind-the-scenes-programs [sic] calculates the U&C amount by averaging the reportings for all zips associated with that procedure that have more than 4 reportings. If there are less than 4 reportings for all zips associated with the procedure, then the procedure does not get updated at all.

As for how it gets different amounts for the different zips, Step 5 is where that happens. Factors are calculated for the mean and each of the percentiles for each zip area. Then, Step 6 multiplies those factor amounts by the Relative Value for the procedure to get the amounts that are updated to the database for each zip.

Please let me know if this helps. I know that it is 'clear as mud' and I will try to get you a more 'user friendly' explanation of this process as soon as I can get around to it.

71. CIGNA does not advise physicians like the Individual Plaintiffs and the Class when it has used a "default" formula or other "behind-the-scenes" program to price UCR.

72. Each of these “default” methods violates CIGNA’s obligations to both its members and their medical providers.

73. In addition to using differing “default” formulas, CIGNA’s claims platforms applied different rounding rules to price UCR rates during the Class Period. The use of different rounding rules means that the Individual Plaintiffs and the Class will receive a different UCR amount based solely on whether the CIGNA platform used the exact Ingenix dollar amount or applied rounding rules.

74. The inconsistent pricing of UCR across CIGNA’s numerous claims platforms means that the Individual Plaintiffs and the Class received different UCR amounts for the same date, same procedure in the same geographic area simply due to the fortuity of which claims platform processed their claim.

75. By using Ingenix data and other improper Nonpar pricing methods to reduce reimbursements during the Class Period, CIGNA violated, and continues to violate, its legal obligations to Plaintiffs and the Class.

76. CIGNA failed to provide Plaintiffs and the Class with material information regarding out-of-network determinations. CIGNA’s lack of disclosure and misrepresentations violates ERISA, RICO, the Sherman Act, and federal common law. By failing to give the Individual Plaintiffs and the Class an explanation of the basis for their UCR or other Nonpar determinations, CIGNA failed to provide the “full and fair review” required by ERISA. CIGNA has entered into an illicit agreement with Ingenix that neither will disclose database information to conceal the defects from members and physicians alike.

77. CIGNA violated various fiduciary, statutory, and common law duties to the Individual Plaintiffs and the Class by not providing a full and fair appeals process and the

underlying data on which they purportedly relied on to deny their assigned benefits, and by failing to make decisions untainted by their own self-interest.

**PLAINTIFFS' AND THE CLASS' EXPERIENCE WITH CIGNA**

78. During the Class Period, CIGNA harmed Plaintiffs and the Class by systematically making improper UCR determinations that reduced lawful reimbursement amounts for Nonpars without valid or compliant data to support such determinations. CIGNA further harmed the Class by misapplying Par policies to Nonpar claims, and by delaying payment to Nonpars under the pretext of negotiation. As a result of these actions, Plaintiffs and the Class were financially harmed and forced to exhaust significant time and resources appealing CIGNA's unlawful determinations through a process deliberately designed to deny, delay, and impede Nonpars from obtaining their rightful reimbursement.

**Dr. Gardner Has Been Harmed By CIGNA's Unlawful Practices**

79. Plaintiff Dr. Gardner is a plastic surgeon specializing in breast reconstruction surgery for cancer patients. He is licensed to practice medicine in the State of New Jersey and has served as the President of the New Jersey Society of Plastic Surgeons and as Chapter Councilor Member for the American College of Surgeons. Dr. Gardner is also the Chairman of the Plastic Surgery Department at Overlook Hospital and works in private practice at Summit Plastic Surgery.

80. At all relevant times, Dr. Gardner has been a Nonpar in CIGNA's physicians' networks. Throughout the Class Period, Dr. Gardner provided out-of-network healthcare services to CIGNA plan enrollees. Dr. Gardner's experience with CIGNA's unlawful business practices is typical of what has happened to the Class as a whole.

81. The high cost of medical care makes it difficult for many patients to pay out of pocket for treatment at the time of service. Instead, patients rely on their health plans to

reimburse physicians for their services, leaving the Individual Plaintiffs and the other Class members to advance the cost of their procedures. As collateral for payment, patients sign a form assigning their health benefits to Dr. Gardner in advance of treatment. This form includes an express authorization by the patient for CIGNA to remit payment directly to Dr. Gardner for covered services. To further ensure receipt of payment, Dr. Gardner seeks preauthorization from CIGNA for each surgical procedure that he intends to perform. At no time during the preauthorization process, however, does CIGNA inform Dr. Gardner of what his remuneration will be. He does not find out his compensation until – at the earliest – after a procedure has been performed and a claim for payment is submitted to CIGNA. More often, Dr. Gardner will not find out what his compensation will be until after a series of lengthy negotiations with CIGNA, described in detail below.

82. At all relevant times, Dr. Gardner utilized a HCFA 1500 or more recently a CMS 1500 form, to submit claims for payment to CIGNA. Dr. Gardner's smaller claims are routinely submitted electronically. Once an electronic claim is submitted it passes through a clearinghouse before reaching CIGNA. The larger of Dr. Gardner's claims, which are accompanied by lengthy operative reports, are submitted to CIGNA on paper via the US Postal Service. No matter whether large or small, all of Dr. Gardner's claims are submitted to CIGNA using CPT codes, Healthcare Common Procedure Coding System ("HCPCS"), and modifiers, as necessary.

83. At all relevant times, Dr. Gardner expected to be reimbursed by CIGNA at the lesser of his billed charges or the current UCR rate, which is defined as the "usual fee for a procedure charged by the majority of physicians with similar training and experience within the same geographical area."

84. Rather than simply pay Dr. Gardner the lesser of his billed charges or UCR rates, CIGNA instead routinely and deliberately reimbursed his claims at below UCR levels, requiring

him to exhaust time and energy first identifying and then appealing improperly reimbursed claims.

85. CIGNA unlawfully diminished Dr. Gardner's compensation by improperly calculating UCR rates and then misapplying these rates to his claims. Dr. Gardner's EOBs and Remittance Advices often state that his billed charges purportedly exceed the UCR rate for the geographic area where the services were performed. However, nowhere on the EOBs, Remittance Advices or elsewhere in any other correspondence sent to Dr. Gardner does CIGNA discuss or identify how it actually calculates UCR. The EOBs do not even specify whether Ingenix data or some other methodology was used in these calculations. Instead, the EOBs plainly state that the rates have been "determined by CIGNA." With its methods for calculating UCR shrouded in a veil of secrecy, CIGNA has been able to derive improper rates using faulty data, and apply them to Nonpar claims in order to diminish lawful reimbursement.

86. Upon information and belief, CIGNA uses Ingenix data, among other sources, to understate the true market rates of medical care performed by Nonpars. The improper use of this data has caused both patients and Nonpars to experience significant losses. Patients are harmed because payors like CIGNA are not reimbursing out-of-network services at appropriate levels, which results in Nonpars increasingly billing their patients for amounts charged, which exceed the amounts CIGNA covers. Nonpars like the Individual Plaintiffs and the Class are harmed because they are not always able to collect these balances from patients and are forced to take a loss for their services. Moreover, because Nonpars are often unaware of the scheme that results in payors like CIGNA failing to pay appropriate UCR rates, they are either powerless to appeal any such improper determinations or their efforts to appeal these determinations are futile. CIGNA, by contrast, benefits from paying Nonpars at below market rates. If, for example, Nonpars fail to realize that the scheme is the cause of their underpayment, CIGNA has saved

itself significant sums of money. CIGNA's ambiguity regarding its method for calculating UCR rates reflects its participation in this deceptive scheme.

87. CIGNA's EOBs are intentionally uninformative, false, and misleading regarding the use of UCR rates. This ambiguity has resulted in the inconsistent application of UCR to deny the Individual Plaintiffs and the Class their lawful reimbursement. Indeed, CIGNA has repeatedly reimbursed Dr. Gardner differently for identical procedures performed within the same timeframe, with no explanation for the discrepancy. UCR rates should be applied consistently by CIGNA, but instead are selectively used to deny or diminish lawful reimbursement to the Individual Plaintiffs and other Nonpars. This pervasive practice has caused Plaintiffs and the Class financial loss, and has forced them to exhaust time and resources identifying and then appealing improper claims determinations.

88. In addition to the inconsistent application of UCR rates, CIGNA deceptively refers to a "contract amount," "contract schedule," or "discount agreement" on its EOBs to diminish lawful reimbursement to Nonpars. References made to any form of "contract" on EOBs to Nonpars are false and misleading as Nonpars do not have agreements with CIGNA. Indeed, Nonpars like the Individual Plaintiffs are entitled to receive full payment of their billed charges and are not compelled to accept payments that are less than their actual charges for the services that they provide. Any attempt by CIGNA to reimburse the Individual Plaintiffs and other Nonpars at discounted rates under the pretext of a contract is unlawful.

89. CIGNA further diminishes reimbursement to the Individual Plaintiffs and the Class by misapplying Par policies to Nonpar claims. Indeed, CIGNA has improperly imposed multiple procedure reductions, which are only applicable to Pars, on Dr. Gardner's claims to deny and delay him his lawful reimbursement. Dr. Gardner has spent significant time and energy trying to appeal these improper determinations, but is often denied relief even though the

multiple surgery reduction does not apply to him as a Nonpar. CIGNA's unlawful actions are deliberate and are intended to delay or diminish lawful reimbursement to Nonpars.

90. In addition to its improper UCR determinations, inconsistent applications of UCR, and misapplication of Par policies, CIGNA also engaged Dr. Gardner in a series of pre-payment negotiations that were intended to unlawfully deny, diminish and delay lawful reimbursement. Rather than pay Dr. Gardner the lesser of his billed charges or UCR, CIGNA made "offers" to Dr. Gardner to pay adjusted prices below UCR amounts. Under the terms of these offers, acceptance of the adjusted price often constitutes payment in full and prohibits Dr. Gardner from billing the patient for the amount which exceeds the amount of his charges covered by CIGNA (except for deductible, coinsurance, and non-covered items, if any). The only incentive to accept these low-ball offers is to expedite payment. The alternative is to weather the storm by not receiving payment for services until the so-called negotiations are resolved. Resolution of these claims, however, can often take months or even a year to resolve without any assurance that the appropriate amount will be paid. CIGNA uses these so-called pre-payment negotiations as a pretext to delay and diminish reimbursement to the Individual Plaintiffs and the Class.

91. CIGNA's deceitful business practices have forced Dr. Gardner and members of the Class to engage in a laborious and time consuming series of pre-payment negotiations over the telephone to receive his lawful reimbursement, with no guarantee that CIGNA's payment will be satisfactory. Upon information and belief, CIGNA's wrongful practices are intended to strong-arm Nonpars into agreeing to accept a lower rate than they rightfully deserve by holding on to already earned monies for prolonged periods under the pretext of pre-payment negotiation. CIGNA's hope is that Nonpars like the Individual Plaintiffs will accept a highly discounted fee in exchange for "expedited" payment or give up and sign an agreement to participate in

CIGNA's network at a rate which is more deeply discounted than would be the case were it not for CIGNA's unfair Nonpar payment policies.

92. All of CIGNA's wrongful conduct described above has forced Dr. Gardner and the Class to exhaust significant time and resources appealing unlawfully reimbursed claims. Upon identifying an improper payment for a claim, Dr. Gardner will first appeal CIGNA's determination through a series of telephone calls to Customer Service. If the matter remains unresolved after verbal appeals, Dr. Gardner will then write a formal letter asking CIGNA to reprocess the claim for additional payment. If this too proves ineffective, Dr. Gardner at times will seek to involve the state insurance commissioner to resolve his disputes. Dr. Gardner has frequently exhausted any administrative appeals available through CIGNA without succeeding in obtaining full and proper reimbursement for his services, leaving a lawsuit the only alternative. If an appeal is left unsettled, Dr. Gardner must bill the patient for the amount of his charges which exceeds the amount CIGNA covers, causing the patient to take on a significant out of pocket responsibility because of CIGNA's failure to comply with its contractual obligations. Given the prohibitive cost of breast reconstructive surgery, the nature of these surgeries, which are performed in large part on cancer patients, and the financial hardship associated with paying for treatment, Dr. Gardner is often forced to forgo pursuing further payments from his patients, even though they continue to owe him for his full bills.

93. The Associational Plaintiffs have also been injured by CIGNA's wrongful conduct. CIGNA's wrongful conduct causes direct injury to members of the Associational Plaintiffs by delaying, denying, impeding and reducing lawful compensation for out-of-network services provided to CIGNA's enrollees.

94. CIGNA's wrongful conduct also causes direct injury to the Associational Plaintiffs because they have been, and continue to expend time and resources in dealing with

Defendants' practices. This frustrates the Associational Plaintiffs' purpose, which is to uphold the physician-patient relationship and ensure the delivery of quality medical care to patients.

95. As a result of CIGNA's conduct, the Associational Plaintiffs have been required to devote substantial time and resources to dealing with the issues concerning CIGNA's wrongful out-of-network reimbursement practices. Specifically, the Associational Plaintiffs devote significant time from several of its employees to deal with the practices at issue herein. The Associational Plaintiffs' efforts to counteract CIGNA's unfair and deceptive practices include, *inter alia*, counseling their respective members on how to counteract the practices at issue, monitoring CIGNA's practices, advocating on their members' behalf, and advancing regulatory and legislative reforms.

96. Plaintiffs seek unpaid benefit amounts, treble damages, and declaratory and injunctive relief for CIGNA's conduct described herein, on their own behalf and on behalf of the members of the Associational Plaintiffs, and of the Class as defined herein.

**Dr. Antell Has Been Harmed By CIGNA's Unlawful Practices**

97. Dr. Antell is a Nonpar in CIGNA's provider network. As a Nonpar, Dr. Antell has not agreed to accept any discounted rates from CIGNA for the services he provides, and he is entitled to bill his customary and reasonable charges for his services. Dr. Antell's experience with CIGNA's unlawful business practices is typical of what has happened to the Class as a whole.

98. To provide proper care and treatment for his patients, at both lower risks and lower prices, Dr. Antell has created a certified on-site, state-of-the-art Office Based Surgical ("OBS") facility. Dr. Antell's OBS facility – which was originally incorporated as "850 Park Surgical," and is now incorporated as "Lenox Hill Ambulatory Surgery" – has received accreditation from the American Association for Accreditation of Ambulatory Surgical Facilities

(“AAAASF”) and the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”). The AAAASF Certification states that Dr. Antell’s OBS facility was providing a certificate “for having met the standards of a CLASS C ambulatory surgical facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital body functions.” The JCAHO certificate states that Dr. Antell’s OBS facility “has been accredited” by the JCAHO, “which has surveyed this organization and found it to meet the requirements for accreditation.”

99. Dr. Antell has assumed substantial costs, both in establishing and maintaining his OBS facility, through which he provides the highest quality of care to his patients. As a result, as part of his customary and reasonable practice, Dr. Antell charges a “facility fee” for services he performs there to compensate him for the additional costs and effort of maintaining the facility.

100. Dr. Antell’s OBS facility satisfies the requirements of the Public Health Law (“PHL”) of the State of New York. Section 230-d of the Public Health Law defines Office-Based Surgery as follows:

“Office-based surgery” means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure where such surgical or other invasive procedure or liposuction performed by a licensee in a location other than a hospital, as such term is defined in article twenty-eight of this chapter, excluding minor procedures and procedures requiring minimal sedation.

101. Subdivision 2 of the PHL provides that physician practices in which office-based surgery is performed must obtain and maintain full accredited status. The accreditation requirements take effect 18 months from January 14, 2008, or on or before July 14, 2009. Both AAASF and JCAHO, which have accredited Dr. Antell’s OBS facility, have been designated by New York State as accepted accrediting agencies under the PHL, along with the Accreditation Association for Ambulatory Health Care. As a result, Dr. Antell has satisfied all requirements

under New York law for maintaining, operating and performing surgical proceedings in his OBS facility.

102. While providing services to CIGNA patients, Dr. Antell has repeatedly been subjected to reductions in reimbursements based on CIGNA's representations that his bills are in excess of UCR amounts. In doing so, CIGNA has relied improperly on the flawed and inadequate Ingenix database, which fails to identify proper UCR rates.

103. With respect to the UCR reductions CIGNA imposed on Dr. Antell, any exhaustion of administrative remedies with respect to the UCR determination would be futile, because CIGNA, as a matter of policy, refuses to alter or reprocess claims that have been processed pursuant to the Ingenix database. Alternatively, Dr. Antell should be deemed to have exhausted any claims that otherwise were not exhausted, due to CIGNA's inadequate disclosure concerning grievance procedures and its violation of ERISA and the applicable ERISA regulations.

104. In addition to the UCR reduction, CIGNA has also refused to reimburse Dr. Antell for his facility fees relating to surgeries performed in his OBS facility, claiming that he does not have a properly authorized facility.

105. This determination not to pay fees is contrary to CIGNA's own prior determinations, in which it had recognized Dr. Antell's OBS facility and agreed that he could provide services in that facility for CIGNA patients.

106. The American Society of Plastic and Reconstructive Surgeons, Inc. ("ASPRS") has similarly taken the position that facility fees for OBS facilities are proper and should be reimbursed. As stated in a Position Paper of the ASPRS:

It is the position of the American Society of Plastic and Reconstructive Surgeons that reimbursement of reasonable charges for facilities accredited by AAAAPSF, or other recognized and approved accrediting agencies, for reconstructive plastic surgery procedures can play a significant role in reducing the cost of health care

in general. This is supported by the fact that on an average, 60 percent of the procedures performed by plastic surgeons are reconstructive, as opposed to cosmetic. It is recognized that over 50 percent of those reconstructive procedures can be safely performed in office-based facilities.

\* \* \* \*

A growing number of large and respected third-party payors have amended their existing policies or liberalized their policy interpretation and are now providing reimbursement for in-office facility charges.

107. Based on information and belief, the patients' CIGNA plans have no provision that health care services provided through an OBS facility, or that a facility fee charged for such services, would not be covered or reimbursed.

108. Given that charging and being reimbursed for facility fees for services provided at an accredited OBS facility is generally recognized in the medical and insurance community, there is no basis for CIGNA to deny coverage for Dr. Antell's facility fees. Dr. Antell was entitled to charge his patient for the facility fee for his OBS facility and, under the terms and conditions of its health care plans, CIGNA was obligated to pay such a fee as with UCR fees for Nonpar services.

109. Dr. Antell has appealed CIGNA's denial of coverage for his OBS facility, and has exhausted all available appeal procedures. Moreover, any further appeals would be futile due to CIGNA's firm practice of refusing to pay for OBS facilities used by Nonpars.

110. Based on the foregoing, in addition to seeking relief on behalf of himself and all other similarly situated physicians who have been subjected to improper UCR reductions based on CIGNA's reliance on the Ingenix databases or other undisclosed policies to set UCR rates, Dr. Antell also seeks relief on behalf of himself and all other similarly situated physicians who have been denied coverage for facility fees for OBS facilities accredited by the accepted accreditation entities, including but not limited to the AAAASF and JCAHO.

111. The Associational Plaintiffs have also been injured by CIGNA's wrongful conduct. CIGNA's wrongful conduct causes direct injury to members of the Associational Plaintiffs by delaying, denying, impeding and reducing lawful compensation for out-of-network services provided to CIGNA's enrollees.

112. CIGNA's wrongful conduct also causes direct injury to the Associational Plaintiffs because they have been, and continue to expend time and resources in dealing with Defendants' practices. This frustrates the Associational Plaintiffs' purpose which is to uphold the doctor patient relationship and ensure the delivery of quality medical care to patients.

113. As a result of CIGNA's conduct, the Associational Plaintiffs have been required to devote substantial time and resources to dealing with the issues concerning CIGNA's wrongful out-of-network reimbursement practices. Specifically, the Associational Plaintiffs devote significant time from several of its employees to deal with the practices at issue herein. The Associational Plaintiffs' efforts to counteract CIGNA's unfair and deceptive practices include, *inter alia*, counseling their respective members on how to counteract the practices at issue, monitoring CIGNA's practices, advocating on their members' behalf, and legislating for insurance reform.

114. Plaintiffs seek unpaid benefit amounts, treble damages and declaratory and injunctive relief for CIGNA's conduct described herein, on their own behalf and on behalf of the members of the Associational Plaintiffs, and of the Class as defined herein.

#### **ANTITRUST ALLEGATIONS**

115. CIGNA has committed, and conspired to commit, with its competitors including, among others, UnitedHealthcare and CIGNA, and/or with other third parties numerous violations of the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq.* CIGNA has combined, conspired and/or agreed with its co-conspirators, including UnitedHealthcare, CIGNA, and Ingenix to

unreasonably restrain trade in per se violation of Section 1 of the Sherman Act by price fixing with regard to paying reasonable and customary rates for Nonpar transactions.

**INTERSTATE COMMERCE**

116. CIGNA, participates in, and affects, interstate commerce.

117. CIGNA's activities, including the administration and operation of health plans and managed care plans, in every state in the United States, are in the regular, continuous and substantial flow of interstate commerce, and have a substantial effect upon interstate commerce.

118. CIGNA's unlawful activities, concerted actions, conspiracy to restrain trade, and agreement to fix prices substantially affect and restrain the operation of interstate commerce.

**RELEVANT MARKET**

119. The relevant product and/or service market affected by CIGNA's conduct is the market for Nonpar services

120. The relevant geographic market for the purposes of this action is the United States of America.

**CIGNA'S AGREEMENT TO FIX PRICES AND  
ENGAGE IN OTHER ANTI-COMPETITIVE CONDUCT**

121. CIGNA reached an agreement with its competitors, including UnitedHealthcare, CIGNA and/or a number of other non-parties to determine UCR rates using primarily the Ingenix database, as described above, even while knowing that use of the database would result in artificially low reimbursements to Class members. The above concerted action among these "competitors," including CIGNA and its co-conspirators, has resulted in unlawful and anticompetitive price fixing agreements, and other horizontal restraints of trade and anticompetitive behavior.

122. UnitedHealthcare, via its alter ego Ingenix, facilitates the direct horizontal agreements through the compiling and sharing of competitive information and UCR rate data among all the co-conspirators.

123. As stated above, many CIGNA and other contributors to Ingenix are entitled to discounted use of the Ingenix database simply for continuing to submit data at the level at which they submitted data when the database was owned by HIAA.

124. UnitedHealthcare's ownership of the Ingenix database and sharing of the database's compiled pricing data with each of its competitors appears to be a textbook situation of adopting a benchmark for determining the price to be paid to Nonpars for out-of-network medical services.

125. CIGNA engaged in price fixing when it agreed with its co-conspirators, including UnitedHealthcare to utilize precisely the same flawed database to determine the UCR amounts for out-of-network medical services, which lead to them paying substantially the same reduced amounts for services rendered to their subscribers.

126. The Department of Justice Antitrust Division notes in its Price Fixing "Primer" that price fixing agreement can take many forms. "[A]ny agreement that restricts price competitions violates the law." It adds that "examples of price fixing agreements include those to:

- a. Establish or adhere to price discounts
- b. Hold prices firm
- c. Adopt a standard formula for computing prices
- d. Adhere to a minimum fee or price schedule."

<http://www.usdoj.gov/atr/public/guidelines/211578.htm>.

127. CIGNA, along with its co-conspirators, adopted a standard formula for making UCR determinations, based on a database that is designed and intended to reduce reported charges artificially, and each has agreed to a method of determining the maximum price or fee, via database schedule, that it will pay for out-of-network charges. This alone amounts to an agreement to fix prices.

128. CIGNA's agreement also gives it, collectively with its competitors, tremendous market power to set UCR rates well below those which would exist in a competitive marketplace. In fact, no competitive pressure to raise UCR rates exists while all the conspirators act collectively to reduce prices. Without agreement and collective action between them, including the exchange and compilation of relevant pricing data, CIGNA would be unable to systematically and across the board reduce their UCR rates paid. This alone amounts to a horizontal agreement to fix prices.

129. In addition to agreeing to price their UCR rates using the exact same database, which is inadequate for the purpose for which it is used, the insurers also engage in parallel behavior. The insurers have substantially similar contracts with their customers in which all material provisions are the same; they all submit UCR rate data to the databases to be compiled; they are all aware that the data submitted leads to skewing the relevant UCR determinations downward; and they all utilize the Ingenix database to determine UCR rates. These parallel behaviors allow their price fixing agreement to effectively depress the UCR rates paid to Nonpars for services rendered to plan subscribers, and otherwise reduce competition among would-be competitors.

130. Collusion, conspiracy and agreement are facilitated in this market as it is heavily concentrated with a standardized product and with numerous opportunities for CIGNA and its co-conspirators to agree and collude, including involvement and participation in the same trade

associations and widespread availability of the Ingenix database. Additionally, where pricing information is shared among the parties, defection from the agreement is easy to detect as it is there for all to see in the data contributed to Ingenix.

131. There is virtually no incentive for CIGNA, or its co-conspirators, to compete in the out-of-network UCR determination portion of their business.

132. Additionally, UCR merely represents a cost of doing business with CIGNA. Agreement to systematically reduce these costs benefits each conspirator without affecting its ability to compete for customers. This benefit cannot be achieved without collective agreement.

133. In fact, CIGNA and its co-conspirators enjoy monopoly status or significant market power in certain areas or markets. The agreement to utilize the same flawed database for UCR determinations allows CIGNA to enjoy the market power of its counterparts through the use of competitors' data.

134. The agreement between CIGNA and its co-conspirators to fix and suppress prices also has the perverse effect of strong-arming doctors into becoming Pars of the various "networks" where further cost reducing measures and other methods of control can be imposed on physicians.

135. A market with the characteristics described above facilitates collusion and agreement to fix prices, and detection by co-conspirators and discipline are also easy to maintain.

136. As noted above, it was only after investigation by the New York Attorney General, in conjunction with a pending class action lawsuit, that UnitedHealthcare agreed that the database used to determine UCR must be independently maintained and that the agreement to fix prices using the database must be abandoned.

**ANTITRUST INJURY**

137. CIGNA's market power results from the combined power of its competitors, who also reached agreement to utilize the same database to determine UCR rates and whose role as primary payors gives them the power to impose artificially low UCR rates and other anti-competitive restrictions on doctors that could not exist in a competitive market.

138. Competition among the payors has also been reduced by the agreement to improperly reduce UCR amounts.

139. Without the agreement to fix UCR rates and reduce competition among payors, the Individual Plaintiffs and the Class would have been, and would have continued to be paid more for the out-of-network medical services that they rendered to CIGNA's subscribers.

**CLASS ACTION ALLEGATIONS**

140. The Individual Plaintiffs bring this action on behalf of themselves and all others similarly situated under Rule 23 of the Federal Rules of Civil Procedure. The requirements of subparts 23(a) and (b)(1), (b)(2) and (b)(3) of the Federal Rules of Civil Procedure are met. The Individual Plaintiffs bring this class action on behalf of a "RICO-Antitrust Class," defined as:

All non-participating physicians and physicians' groups, within the boundaries of the United States of America, who were entitled to receive benefits from any CIGNA insured or administered health plan, at any time during the period commencing January 1, 2005 through the present and were paid less than their billed charge for "out-of-network" medical services rendered to any CIGNA subscriber.

141. The Individual Plaintiffs also bring this action on their own behalf and on behalf of an ERISA Sub-Class defined as follows:

All non-participating physicians and physicians' groups, within the boundaries of the United States of America, who were entitled to receive benefits from any CIGNA insured or administered group health plan subject to ERISA, at any time during the period commencing January 1, 2005 through the present and were paid less than their billed charge for "out-of-network" medical services rendered to any CIGNA subscriber.

Excluded from the RICO-Antitrust Class and the ERISA Sub-Class are any judge(s) or justice(s) to whom this action is assigned, as well as any relative of such judge(s) or justice(s) within the third degree of relationship, and the spouse of any such person.

**RULE 23(a)**

**Numerosity**

142. This putative Class includes thousands of Nonpars throughout the United States and is therefore so large to make joinder of all members impracticable within the meaning of Fed. R. Civ. P. 23(a)(1).

**Commonality**

143. Pursuant to Fed. R. Civ. P. 23(a)(2), there are questions of law or fact common to all class members, including, but not limited too, the following:

- a. Whether the amounts paid to the Class, have been fixed, artificially maintained, and/or stabilized at levels below those that would prevail in a competitive market;
- b. Whether CIGNA's use of the Ingenix database or its other Nonpar pricing methods (including default formulas) to calculate usual, customary, or reasonable charges in determining Nonpar reimbursement violated ERISA, RICO, or common law;
- c. Whether CIGNA's Nonpar benefit reductions violated ERISA, RICO, the Sherman Act, or common law;
- d. Whether CIGNA misapplied Par policies such as multiple procedure reductions to claims submitted by Plaintiffs and the Class;
- e. Whether CIGNA's denial of coverage for accredited OBS facilities violated ERISA, RICO, or common law.
- f. Whether CIGNA's use of the Ingenix database itself resulted in lower UCR determinations than were available in a market with appropriate information;

g. Whether CIGNA's failure to properly disclose the specific reason for UCR and Nonpar pricing methods in its EOBs as well as failure to disclose material information (including the offer to disclose the relevant evidence) violated ERISA or common law;

h. Whether ERISA requires each Class member to prove exhaustion or futility;

i. Whether CIGNA violated RICO and, if so, the appropriate damages to be awarded;

j. Whether CIGNA combined, conspired and/or agreed with its co-conspirators in a price fixing conspiracy that sought, and was able, to artificially lower, fix or maintain the price paid to Plaintiffs and the Class by CIGNA as UCR rates; and

k. Whether interest should be added to the payment of unpaid benefits under ERISA or common law.

#### **Typicality**

144. The claims of the Individual Plaintiffs are typical of the claims of the defined Class, within the meaning of Fed. R. Civ. P. 23(a)(3), and are based on and arise out of the same uniform and standard illegal practices of the Defendants alleged by the Plaintiffs.

145. The proposed class representatives state claims for which relief can be granted that are typical of the claims of absent class members. If litigated individually, the claims of each class member would require proof of the same material and substantive facts, rely upon the same remedial theories, and seek the same relief.

#### **Adequacy**

146. The Individual Plaintiffs are committed to pursuing this action and are prepared to serve the proposed Class in a representative capacity with all of the obligations and duties material thereto. The Individual Plaintiffs will fairly and adequately represent the interests of the members of the class within the meaning of Fed. R. Civ. P. 23(a)(4) and have no interests

adverse to, or which directly and irrevocably conflict with, the interests of the other Class members.

147. The Individual Plaintiffs have retained competent counsel experienced in class action litigation. Said counsel will adequately prosecute this action, and will assert, protect and otherwise well represent the named Class representatives and absent Class members.

**RULE 23(b)(1)(A) AND (B)**

148. The prosecution of separate actions by individual Class members would create a risk of adjudication with respect to individual Class members which would, as a practical matter, be dispositive of the interests of other members of the Class who are not parties to this action, or could substantially impair or impede their ability to protect their interests.

149. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent of varying adjudications with respect to individual members of the Class which would establish incompatible rights within the Plaintiff Class.

**RULE 23(b)(2)**

150. CIGNA's actions are generally applicable to the class as a whole, and the Individual Plaintiffs seek equitable remedies with respect to the class as a whole, within the meaning of Fed. R. Civ. P. 23(b)(2).

**RULE 23(b)(3)**

151. The common questions of law and fact enumerated above predominate over individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy, within the meaning of Fed. R. Civ. P. 23(b)(3). Common or general proof will be used for each class member to establish each element of their ERISA, RICO and antitrust claims. Additionally, proceeding as a class action is superior to other available methods of adjudication. The likelihood that individual members of the Class will prosecute separate actions

is remote due to the time and expense necessary to conduct such litigation since the cost of litigation far exceeds what any one class member has at stake.

**COUNT I**

**BREACH OF PLAN PROVISIONS FOR BENEFITS  
IN VIOLATION OF ERISA § 502(A)(1)(B)  
(On Behalf of All Plaintiffs and the Class)**

152. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

153. The Individual Plaintiffs and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits claims to CIGNA.

154. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

155. During the Class Period, CIGNA breached its plan provisions for benefits by underpaying UCR and other out-of-network reimbursement amounts in ERISA healthcare plans to Plaintiffs and the Class in violation of § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B).

156. CIGNA's breaches included, among other things, the misuse of the Ingenix database and other improper methods to both calculate UCR and reduce other benefits paid to Nonpars for out-of-network medical services.

157. Under the terms of its health plans, CIGNA administers benefits and is a fiduciary.

158. In certain self insured plans which are sometimes designated Administrative Services Only or "ASO," CIGNA makes the final decision on benefit appeals and/or has been given authority, responsibility and discretion (hereinafter "discretion") with regard to benefits.

159. Where CIGNA acts as a fiduciary or performs discretionary benefit determinations or otherwise exercises discretion, or determines final benefit appeals, CIGNA is

liable for underpaid benefits to Plaintiffs and the Class in both fully insured and ASO ERISA health plans.

160. Pursuant to 29 U.S.C. § 1132(a)(1)(B), Plaintiffs and the Class are entitled to recovery for unpaid benefits and declaratory relief relating to CIGNA's violation of the terms of its health care plans.

## **COUNT II**

### **FOR DECLARATORY RELIEF RELATING TO CIGNA'S VIOLATION OF ERISA (On Behalf of All Plaintiffs and the Class)**

161. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

162. The Individual Plaintiffs and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits claims to CIGNA.

163. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

164. Under federal law, Plaintiffs and the Class are entitled to receive protections under ERISA including (a) a "full and fair review" of all claims denied by CIGNA; (b) compliance by CIGNA with ERISA claims procedure regulations; and (c) receipt of accurate materials summarizing such group health plans, known as Summary Plan Descriptions ("SPD") materials under § 102 of ERISA, 29 U.S.C. § 1022.

165. Any time CIGNA deprived its members of "full and fair review" or proper compliance with ERISA claims procedure regulations, it violated § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and thus violated the rights of Plaintiffs and the Class.

166. Although CIGNA was obligated to do so, it failed to provide a "full and fair review" of denied claims pursuant to § 503 of ERISA, 29 U.S.C. § 1133, and its implementing

regulations, *inter alia*, by failing to disclose the “specific reasons” for benefit denials, failing to disclose data and/or the methodology used to determine UCR or Nonpar reimbursement, and failing to comply with appeal procedures imposed by ERISA and the federal common law.

167. Applicable federal claims procedure regulations set forth minimum standards for claim procedures, appeals, notice to members and the like. By engaging in the conduct described herein including, but not limited to, making benefit determinations for Nonpar claims that are inconsistent with the terms of group health plans, and failing to disclose information concerning the data and/or methodology it used to determine UCR or other Nonpar reimbursements, CIGNA failed to comply with such regulations

168. The consequences of CIGNA’s failure to comply with the regulations (as well as federal common law), are that CIGNA failed to provide reasonable claims procedures and failed to make required disclosures to Plaintiffs and the Class.

169. Administrative remedies are deemed exhausted, *inter alia*, by virtue of the invalid Ingenix database, other invalid Nonpar pricing methods discussed *supra*, and CIGNA’s failure to provide reasonable claims procedures. By virtue of the conduct alleged in this Complaint, any appeal would have been futile.

170. CIGNA’s failure to supply accurate SPDs and accurate information is redressable under § 502(c) of ERISA, 29 U.S.C. § 1132(c).

171. CIGNA’s failure to disclose material information about its UCR and other methods for pricing Nonpar claims (including default formulas and rounding rules) constitute violation of federal common law, which obligates fiduciaries such as CIGNA to provide this material information.

172. Plaintiffs and the Class have been harmed by CIGNA’s failure to provide a “full and fair review” of appeals submitted under § 503 of ERISA, 29 U.S.C. § 1133, by CIGNA’s

failure to disclose information relevant to appeals or to comply with ERISA claims procedure regulations, in violation of ERISA and the federal common law, and by CIGNA's failure to provide accurate information, in violation of federal common law and § 102 of ERISA, 29 U.S.C. § 1022.

173. Plaintiffs and the Class are entitled to a declaration by this Court that CIGNA's actions as alleged herein are in violation of its duties and obligations of ERISA.

### **COUNT III**

#### **VIOLATION OF FIDUCIARY DUTIES OF LOYALTY AND DUE CARE IN VIOLATION OF § 404 OF ERISA (On Behalf of All Plaintiffs and the Class)**

174. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

175. The Individual Plaintiffs and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits claims to CIGNA.

176. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

177. During the Class Period, CIGNA acted and continues to act as a fiduciary of its members' health plans, as the term fiduciary is interpreted under § 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). At such times, CIGNA also acted and acts as a fiduciary for self-insured plans, including by deciding final appeals.

178. As a functional fiduciary under ERISA and as a claims fiduciary making final appeal decisions for self-insured plan members, CIGNA owes Plaintiffs and the Class a duty of care, defined as an obligation to act prudently, with the care, skill, prudence and diligence that a prudent fiduciary would use in the conduct of an enterprise of like character. Further, fiduciaries must ensure that they are acting in accordance with the documents and instruments governing the

plan, in accordance with § 404(a)(1)(B) and (D) of ERISA, 29 U.S.C. § 1104(a)(1)(B) and (D). In failing to act prudently, and in failing to act in accordance with the documents governing the plan, CIGNA violated its fiduciary duty of care.

179. As a fiduciary of health plans under ERISA, CIGNA owed Plaintiffs and the Class a duty of loyalty, defined as an obligation to make decisions in the interest of members, and to avoid self-dealing or financial arrangements that benefit the fiduciary at the expense of members, in accordance with § 406 of ERISA, 29 U.S.C. § 1106. Thus, CIGNA cannot make benefit determinations for the purpose of saving money at the expense of its members.

180. During the Class Period, CIGNA violated its fiduciary duty of loyalty, *inter alia*, by using the Ingenix database and other methods for pricing Nonpar claims (including default formulas and rounding rules) that benefited itself at the expense of members as well as Plaintiffs and the Class. In addition, CIGNA violated (and continues to violate) its fiduciary duty of loyalty by failing to inform members of material information, including but not limited to flaws in the data and methodology used to determine UCR reimbursement. In fact, during the Class Period, by using the U.S. mails and interstate wire facilities, CIGNA made representations *inter alia* about the Ingenix database that it knew were untrue. As a data contributor to the Ingenix database, CIGNA knew many of the flaws that make the Ingenix data an inappropriate basis for UCR.

181. In relying on the Ingenix database or other improper pricing methods, which were noncompliant with its contractual obligations and invalid to make UCR determinations, and in applying, *inter alia*, a reduction for multiple procedures that was not authorized and nowhere disclosed to members in their plan documents, CIGNA violated its fiduciary obligations to Plaintiffs and the Class.

182. Plaintiffs and the Class are entitled to assert a claim for relief for CIGNA's violation of its fiduciary duties under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), including declaratory relief, and may seek removal of any fiduciary that breached its duties.

#### **COUNT IV**

##### **VIOLATIONS OF RICO, 18 U.S.C. 1961(c) (On Behalf of All Plaintiffs and the RICO-Antitrust Class)**

183. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein. This claim is asserted by Plaintiffs on their own behalf and on behalf of RICO-Antitrust Class members.

184. The Individual Plaintiffs and the RICO-Antitrust Class have standing to pursue these claims as assignees of their patients' out-of-network benefits and as third party beneficiaries of their patients' out-of-network benefits.

185. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

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

187. At all relevant times, and as described in this Complaint, CIGNA carried out its underpayment scheme to defraud Plaintiffs and the RICO-Antitrust Class in connection with the conduct of an association-in-fact "enterprise," within the meaning of 18 U.S.C. § 1961(4), comprised of CIGNA and Ingenix (the "Enterprise").

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

189. As described herein, the Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which

CIGNA has engaged. In addition, the members of the Enterprise function as a structured and continuous unit, and performed roles consistent with this structure. The members of the Enterprise performed certain legitimate and lawful activities that are not being challenged in this Complaint, including the provision of health insurance and plan and claims administration services by CIGNA, which was done for many claims lawfully and without resort to unlawful practices. However, the collection and dissemination of health insurance information by Ingenix was not legitimate when it involved the creation, use and dissemination of invalid data for use in making UCR determinations. Aside from legitimate activities carried out by the members of the Enterprise, its members used the Enterprise's structure to carry out the fraudulent and unlawful activities alleged in this Complaint including, but not limited to, intentional underpayment of benefits to Plaintiffs and the Class resulting from CIGNA's use of flawed and invalid data for its UCR determinations.

190. The purpose of the Enterprise was to create a mechanism or vehicle by which CIGNA could reduce payments to Plaintiffs and the RICO-Antitrust Class for out-of-network services through the use of flawed and invalid data that could not easily be challenged effectively. In particular, as described herein, the Enterprise created what appeared to be an appropriate and unassailable database which reported actual charge data; the Ingenix database was designed to appear valid as a basis for UCR when, in fact, it is and was invalid. Through their roles in the Enterprise, Ingenix benefited directly by enhancing its ability to earn licensing fees through the sale of the Ingenix databases and indirectly through the monies saved by UnitedHealthcare, its parent corporation, while CIGNA benefited by reducing the amount of benefits it paid to Plaintiffs and the Class for their out-of-network services through the use of the Ingenix database to price UCR. (During the Class Period, Ingenix also used data submitted by

data contributors, such as CIGNA, to create other products, the licensing and sale of which directly benefited Ingenix.)

191. As alleged herein, although Ingenix issues a disclaimer to the users of the Ingenix databases, CIGNA continued to use the Ingenix databases in a manner directly at odds with the disclaimer, while Ingenix knew that its data users were using the Ingenix databases improperly to make UCR determinations and failed to stop it. At the same time it was issuing a disclaimer in a misguided effort to provide itself (and UnitedHealthcare) with legal protection, Ingenix was also promoting the Ingenix database as a cost-saving mechanism that could save substantial sums to those (such as CIGNA) who improperly used and relied upon them in making UCR determinations.

192. Ingenix provided extensive "litigation support," including vouching for data used to price UCR by its data users. Ingenix employed staff to assist data users, including testifying in court, testifying in depositions, supplying documentation and otherwise bolstering the users' use of Ingenix data to price UCR. Thus, CIGNA and Ingenix expressly observed the disclaimer in the breach, despite the fact that the disclaimer correctly stated that the Ingenix database could *not* be used as a basis for making UCR determinations. CIGNA provided data to Ingenix which it knew would be edited by Ingenix in a manner which precluded its use for UCR.

193. Similarly, as alleged herein, Ingenix and CIGNA knew that UCR data is invalid if it fails to reflect necessary information. CIGNA knew that Ingenix actually used only four basic data points (billed charge, the first 3 digits of the provider zip code, date of service and five digit CPT code without modifier) to produce the final Ingenix database. Both CIGNA and Ingenix knew that the Ingenix data was invalid for use as UCR, but CIGNA consummated the fraud in which CIGNA continued to send the four data points to Ingenix and Ingenix continued to use the four data points to create the invalid UCR database which it sent to CIGNA to under price UCR.

194. Ingenix not only sought and accepted CIGNA's incomplete data, but it continued to provide a significant discount to CIGNA and to provide "litigation support" for UCR pricing made by CIGNA using the Ingenix data. Ingenix also failed to conduct any audits or reviews of the data it received from data contributors, including CIGNA. These actions were taken in furtherance of Ingenix's effort to understate UCR amounts for the benefit of the CIGNA-Ingenix Enterprise.

195. CIGNA's submission of data to Ingenix benefited Ingenix, and users of the Ingenix databases, including CIGNA.

196. Ingenix and CIGNA knew that the Ingenix databases were being used without Plaintiffs and the RICO-Antitrust Class ever being informed of the disclaimer or the inherent flaws in the Ingenix databases. For example, CIGNA falsely reported to Plaintiffs and RICO-Antitrust Class members, via U.S. mail and interstate wire communications, that its reductions in amounts paid for out-of-network services were based on UCR when, in fact, the reductions were based on flawed and invalid numbers obtained from the Ingenix databases that substantially underreported UCR.

197. During the Class Period, CIGNA participated in the conduct of the Enterprise in order to shift the costs of medical treatment from CIGNA to its members and therefore to Plaintiffs and the RICO-Antitrust Class, to reduce CIGNA's UCR payments and to create an appearance of legitimacy for its out-of-network benefit reductions. Using U.S. mail and interstate wire facilities, CIGNA provided false and misleading information to Plaintiffs and the RICO-Antitrust Class to convert those withheld funds for the Enterprise's own direct and indirect financial gain, and to discourage its members from using out-of-network healthcare providers. Because CIGNA saves money when participating providers render services, the operations of the Enterprise saved CIGNA money at the expense of Plaintiffs and the Class. In turn, the Enterprise

benefited from the pattern of racketeering activity through the reduction of UCR costs by CIGNA and other users of the Ingenix databases, which would not have been obtained absent entry into the Enterprise and was, in addition to the conduct of CIGNA alleged above, the shared goal of the Enterprise for which its members functioned as a continuous unit.

198. CIGNA further used the Enterprise to facilitate its goal of reducing out-of-network benefits paid to Plaintiffs and the Class by submitting incomplete and inadequate data to Ingenix, thereby artificially reducing the numbers that would be reported in the final Ingenix databases and which CIGNA relied upon to make UCR determinations. As part of this fraudulent scheme, as alleged herein, CIGNA intentionally submitted, via U.S. mail and interstate wire facilities, data which it knew would be used to create false databases used to price UCR for its members and members of other healthcare plans. Neither Ingenix nor its parent company, UnitedHealthcare, took steps to stop or prevent or reject inadequate data that Ingenix received from CIGNA and other data contributors. Ingenix was aware of the inadequacy of data contributed by data contributors such as CIGNA, but allowed it to occur, since it was consistent with Ingenix's goal to underreport UCR amounts.

199. If CIGNA had not participated in the conduct of the Enterprise by submitting inadequate data to Ingenix, and using the Ingenix database, it would not have been able to obtain the benefits it did from the Enterprise. Ingenix needed sufficient data to allow it to represent to its customers that the Ingenix database was the largest available and had sufficient numbers to remove any doubt as to their validity. CIGNA knew such representations were being made by Ingenix and used Ingenix's representations for the identical purpose of removing doubt as to their validity. Ingenix needed the data to provide databases to its users to save them money on Nonpar claims. Without data from CIGNA and other large data contributors, the Ingenix database could not have been successfully marketed as the "industry standard" for UCR pricing.

Similarly, CIGNA could not have saved the millions of dollars it did if it had not used the Ingenix databases for making UCR determinations even though it knew that they were flawed and invalid. By using the Ingenix database for making its UCR determinations, misrepresenting them, through use of the U.S. mail and interstate wire facilities, as providing a valid and unassailable basis for such decisions, and deterring its subscribers from challenging or otherwise raising questions over how it set UCR, CIGNA was able to benefit substantially from its role in assisting the control and direction of the Enterprise, along with Ingenix and UnitedHealthcare.

200. Despite their mutual knowledge that the Ingenix data did not determine UCR, CIGNA both defended the Ingenix data when questioned about UCR determinations based on it and by agreement relied on Ingenix to provide detailed “support” so it could defend its use of Ingenix data. Ingenix promised to supply witnesses in court in the event CIGNA’s use of Ingenix data was challenged. In the course of appeals and other questions from CIGNA members, Ingenix provided graphs and other details, vouching for the accuracy and legitimacy of its data. CIGNA then used the detail from Ingenix to vouch for the Ingenix data to the CIGNA member or provider who was questioning UCR.

201. Through its wrongful conduct as alleged herein, CIGNA, in violation of 18 U.S.C. § 1962(c), conducted and participated in the conduct of the Enterprise’s affairs, directly and indirectly, through a “pattern of racketeering activity,” as defined in 18 U.S.C. § 1961(5).

202. CIGNA, acting through its officers, agents, employees and affiliates, has committed numerous predicate acts of “racketeering activity,” as defined in 18 U.S.C. § 1961(5), prior to and during the Class Period, and continues to commit such predicate acts, in furtherance of its underpayment scheme for out-of-network services, including (a) mail fraud, in violation of 18 U.S.C. § 1341, and (b) wire fraud, in violation of 18 U.S.C. § 1343. Such predicate acts include the following:

- (a) mailing, causing to be mailed and/or knowingly agreeing to the mailing of various materials and information including, but not limited to, letters regarding preauthorization approval(s) and/or appeals; pre-payment offers to reduce Nonpar reimbursement levels below UCR levels; and materially false and misleading UCR determinations, EOBs and remittance advices for the purpose of saving CIGNA money at the expense of Plaintiffs and the RICO-Antitrust Class, with each such mailing constituting a separate and distinct violation of 18 U.S.C. § 1341; and
- (b) transmitting, causing to be transmitted and/or knowingly agreeing to the transmittal of various materials and information including, but not limited to, preauthorization approvals; materially false UCR determinations and related explanation of such determinations, by means of telephone, facsimile and the Internet, 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.

203. CIGNA issued false and misleading letters to providers regarding benefits, as well as false and misleading EOBs and Explanations of Payment. CIGNA instructed its claims personnel to make out-of-network benefit reductions that were contrary to the law. CIGNA knew that the data it contributed to Ingenix was inadequate and lacked required data fields essential for Ingenix to evaluate the data and include (or exclude) it in final UCR fee schedules, but CIGNA continued to use the Ingenix databases to make UCR determinations anyway.

204. In furtherance of its underpayment scheme for out-of-network services, CIGNA, in violation of 18 U.S.C. §§ 1341, 1343, 1961 and 1962, repeatedly and regularly used the U.S. mail and interstate wire facilities to further all aspects of the intentional underpayment to Plaintiffs and the RICO-Antitrust Class by delivering and/or receiving materials necessary to carry out the scheme to defraud Plaintiffs and the RICO-Antitrust Class

205. The foregoing communications, sent via U.S. mail and interstate wire facilities, contained false and fraudulent misrepresentations and/or omissions of material facts, had the

design and effect of preventing a meaningful evaluation and review of the Enterprise's UCR determinations, and/or otherwise were incident to an essential part of CIGNA's scheme to defraud Plaintiffs and the RICO-Antitrust Class described in this Complaint. Further, such written communications were used by CIGNA to provide the underpayment scheme for out-of-network services with an appearance of legitimacy and regularity, and/or postpone ultimate discovery and complaint of the underpayment scheme for out-of-network services, thereby making their discovery less likely than if no such mailings or wire transmissions had taken place.

206. As named fiduciaries and claims administrators of various of the CIGNA plans, CIGNA occupied and occupies a position of trust and it had, and has, a special relationship with its members, and therefore with Plaintiffs and the RICO-Antitrust Class, that requires it to accurately represent the terms and conditions of the CIGNA plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

207. Each such use of the U.S. mail and interstate wire facilities alleged in this Complaint constitutes a separate and distinct predicate act of "racketeering activity" and, collectively, constituted a "pattern of racketeering activity."

208. The above-described acts of mail and wire fraud are related because they each involve common members (namely, Plaintiffs and the RICO-Antitrust Class), common out-of-network claim practices, common results impacting upon common victims, and are continuous because they occurred over several years, and constitutes the usual practice of CIGNA and the Enterprise, such that they amount to and pose a threat of continued racketeering activity. CIGNA's scheme to defraud Plaintiffs and the RICO-Antitrust Class is open-ended and on-going.

209. The direct and intended victims of the pattern of racketeering activity described previously herein are Plaintiffs and the RICO-Antitrust Class, whom CIGNA has underpaid out-of-network services.

210. Plaintiffs and the RICO-Antitrust Class were injured by reason of CIGNA's RICO violations because they were underpaid for services rendered to CIGNA's enrollees and were forced to exhaust significant time and resources addressing CIGNA's wrongful practices. CIGNA further deprived them of the knowledge necessary to adequately challenge the underpayments. Their injuries were proximately caused by CIGNA's violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended and natural consequence of CIGNA's RICO violations (and commission of underlying predicate acts) and, but for CIGNA's RICO violations (and commission of underlying predicate acts), they would not have suffered these injuries.

211. Pursuant to Section 1964(c) of RICO, 18 U.S.C. § 1964(c), Plaintiffs and the RICO-Antitrust Class are entitled to recover threefold their damages, costs and attorneys' fees from CIGNA and other appropriate relief.

#### **COUNT V**

#### **VIOLATIONS OF SECTION 664 OF RICO (On Behalf of All Plaintiffs and the ERISA Sub-Class)**

212. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein, including, but not limited to, the allegations of Count IV describing the Enterprise. This claim is asserted by Plaintiffs on behalf of themselves and on behalf the members of the ERISA Sub-Class described above.

213. The Individual Plaintiffs and the ERISA Sub-Class have standing to pursue these claims as assignees of their patients' out-of-network benefits and as third party beneficiaries of their patients' out-of-network benefits.

214. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

215. Section 1961(1)(B) of RICO specifically identifies as a predicate act "any act which is indictable under ... [§] 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.

216. Each of the CIGNA healthcare plans which is an “employee welfare benefit plan” within the meaning of ERISA, 29 U.S.C. § 1002(1)(A), and otherwise is subject to “any provision” of Title I of ERISA is included in this Count.

217. Each of the CIGNA healthcare plans that are subject to ERISA or are a non-ERISA plan funded by insurance coverage CIGNA provides or administers, is subject to Section 664 of Title 18. 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.

218. The governing plan documents warrant that all benefits due under the plans will be paid. By improperly reducing payments on out-of-network claims, CIGNA intentionally caused Plaintiffs and the members of the ERISA Sub-Class to be underpaid guaranteed benefits to which they were otherwise entitled in accordance with the terms of their group health plans.

219. For fully insured health care plans, in which CIGNA both administered the plans and paid the benefits from its own assets, CIGNA benefited from the conversion of assets from its ERISA plans. Whereas these assets should have been held by CIGNA in its fiduciary capacity under ERISA and non-ERISA plans and paid to its members, CIGNA improperly withheld such funds and maintained them as part of its own assets for CIGNA’s own benefit. For self-funded health care plans, CIGNA made final appeal decisions and intentionally caused underpayment of benefits to Plaintiffs and the ERISA Sub-Class in order to justify its receipt of administrative fees. Insurers such as CIGNA benefited in the same way, while Ingenix benefited indirectly through the savings generated by its parent, UnitedHealthcare, and directly through the licensing

fees it received from CIGNA and other insurers who used the flawed Ingenix database to commit RICO violations.

220. CIGNA acted with specific intent to deprive Plaintiffs and ERISA Sub-Class members 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 Plaintiffs, ERISA Sub-Class members and the insurers whose plans it was administering.

221. 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 the intended member, for CIGNA's direct or indirect benefit.

222. As set forth above, CIGNA concocted multiple and multi-faceted schemes, including use of the Ingenix database, to make improperly reduced payments for out-of-network services.

223. In furtherance of its false payment schemes, CIGNA, in violation of 18 U.S.C. §§ 1341 and 1343, repeatedly and regularly used the U.S. mail and interstate wire facilities to advance 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 determinations, appeal determinations, overpayment actions, pre authorization decisions, referrals to collection agencies, representations to regulators, and other materials necessary to effectuate the false payment schemes, as well as to contribute, edit and manipulate the source data for the Ingenix databases.

224. 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 complaints 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 CIGNA's Nonpar pricing methods.

225. As named fiduciaries and claims administrators of various of the CIGNA healthcare plans, CIGNA occupied and occupies a position of trust and it had, and has, a special relationship with Plaintiffs and ERISA Sub-Class members that requires it to accurately represent the terms and conditions of the CIGNA healthcare plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

226. Each such use of the U.S. mail and interstate wire facilities constitutes a separate and distinct predicate act of "racketeering activity."

227. The above-described acts of conversion of employee benefit plan funds, and mail and wire fraud, are related because 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 because they occurred over a significant period of years, and constitute the usual practice of CIGNA such that they amount to and pose a threat of continued racketeering activity.

228. The purpose of CIGNA's false payment scheme was to underpay the guaranteed benefits to which were assigned to Plaintiffs and ERISA Sub-Class members, and convert those withheld funds for its own direct or indirect financial gain. CIGNA created an appearance of regularity and legitimacy by providing false and incomplete information to Plaintiffs and ERISA

Sub-Class members, in order to increase revenue through its plan and claims administration business.

229. The direct and intended victims of the pattern of racketeering activity described previously herein are Plaintiffs and ERISA Sub-Class members, who CIGNA deprived of the complete guaranteed benefits to which they are entitled for out-of-network services.

230. CIGNA's RICO violations injured Plaintiffs and ERISA Sub-Class members 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 violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended and natural consequence of CIGNA's RICO violations (and commission of underlying predicate acts), and but for CIGNA's RICO violations (and commission of underlying predicate acts), Plaintiffs and ERISA Sub-Class members would not have suffered the injuries suffered by them.

231. As a result of its misconduct, CIGNA is liable to Plaintiffs and the ERISA Sub-Class in an amount to be determined at trial. Pursuant to Section 1964(c) of RICO, 18 U.S.C. § 1964(c), Plaintiffs and ERISA Sub-Class members are entitled to recover threefold their damages, and costs and attorneys' fees from CIGNA.

**COUNT VI**

**DECLARATORY AND INJUNCTIVE RELIEF UNDER RICO  
(On Behalf of All Plaintiffs and the Class)**

232. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

233. The Individual Plaintiffs and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits and as third party beneficiaries of their patients' out-of-network benefits.

234. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

235. This claim arises under 18 U.S.C. § 1964(a), which authorizes the district courts to enjoin violations of 18 U.S.C. § 1962, and under 28 U.S.C. § 2201 which authorizes associated declaratory relief.

236. As set forth above, Defendants have violated 18 U.S.C. § 1962 and will continue to do so in the future.

237. Enjoining the Defendants from committing these RICO violations in the future and/or declaring their invalidity is appropriate as Plaintiffs and the Class have no adequate remedy in law, and will, as set forth above, suffer irreparable harm in the absence of the Court's declaratory and injunctive relief.

**COUNT VII**

**VIOLATION OF SECTION ONE OF THE SHERMAN ACT  
(On Behalf of All Plaintiffs and the Class)**

238. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

239. The Individual Plaintiffs and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits and as third party beneficiaries of their patients' out-of-network benefits.

240. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

241. CIGNA, along with Ingenix and its competitors, have combined, conspired and/or agreed with one another, and/or with unnamed co-conspirators, to unreasonably restrain trade in violation of Section One of the Sherman Act, 15 U.S.C. § 1. CIGNA combined, conspired and/or agreed with its co-conspirators in a horizontal price fixing conspiracy that sought, and was able, to artificially lower, fix or maintain the price paid to Plaintiffs and the Class by CIGNA as UCR rates.

242. The above agreement and/or conspiracy to fix prices is a per se violation of Section 1 of the Sherman Act, which operates at the expense of doctors (as well as subscribers) resulting in lower UCR rates of payment to doctors. The above agreement and conspiracy illegally restrains competition in a number of ways, including:

- a. Fixing the price of UCR rates for Nonpar services at levels far below the level that would exist in a truly competitive market;
- b. Accomplishing this price fixing by agreeing to peg the UCR rates to the same Ingenix database thereby using the same essential pricing formula;
- c. Putting extreme additional competitive pressure on Nonpars to become part of particular networks by collusively refusing to even honor competitive market rates for those medical services in the UCR determinations.

243. The above “price fixing” scheme has reduced the amount Plaintiffs and the Class are paid for their services below competitive levels. However, because of the overwhelming market power that the users of Ingenix collectively maintain in the market, and because of the conspiracy and/or agreement among CIGNA, its competitors and/or other parties to fix prices and not compete, there is no way to avoid interaction with the conspiracy. Because of this conspiracy, CIGNA and its co-conspirators, including UnitedHealthcare and CIGNA maintain their oligopoly by reducing costs all the while squeezing payments for out-of-network services to unconscionably low levels.

244. All of the aforementioned agreements and/or conspiracies affect interstate commerce and have resulted in antitrust injury to the Plaintiffs and the Class.

245. Plaintiffs and the Class are entitled to damages under 15 U.S.C. § 15, *et seq.*

246. As a result of the illegal agreements and/or conspiracies, CIGNA has caused the Plaintiffs and the Class to suffer financial loss in that CIGNA, with its agreements to fix prices and collective market strength, pays Plaintiffs and the Class at UCR rates that are set at unconscionably low and uncompetitive levels.

247. As a consequence of CIGNA’s illegal agreements and/or conspiracies, Plaintiffs have suffered and will continue to suffer financial loss and have been injured and will continue to be injured in their business of providing and enhancing medical services. Among other things, Plaintiffs and the Class received less payment for their medical services than they would have in the absence of the agreement among CIGNA the other users of Ingenix to fix the prices paid for Plaintiffs’ out-of-network medical treatment.

248. Plaintiffs and the Class are entitled to recover such actual damages as the jury may find, threefold, plus costs, expenses and attorneys fees.

249. Plaintiffs and the Class further seek injunctive relief in the form of order prohibiting CIGNA from engaging in the anti-competitive, discriminatory and otherwise wrongful behavior described above.

**WHEREFORE**, Plaintiffs and the Class demand judgment in their favor against CIGNA as follows:

1. Certifying the Class as set forth in this Complaint, and appointing the Individual Plaintiffs as Class representatives for these classes;
2. Declaring that CIGNA has breached the terms of its members plans with regard to out-of-network benefits in its members' health plans, and thereby awarding damages to Plaintiffs and the Class for unpaid benefits in ERISA plans to Plaintiffs and the Class, as well as awarding declaratory relief with respect to CIGNA's violations of ERISA;
3. Declaring that CIGNA has failed to provide a "full and fair review" to Plaintiffs and the Class under § 503 of ERISA, 29 U.S.C. § 1133, and awarding declaratory relief with respect to CIGNA's violation of ERISA;
4. Declaring that CIGNA has violated its disclosure obligations under ERISA and the federal common law, including under § 104(b)(4) of ERISA, 29 U.S.C. § 1024(b)(4), and § 102 of ERISA, 29 U.S.C. § 1022, for which Plaintiffs and the Class are entitled to declaratory relief;
5. Declaring that CIGNA violated federal claims procedures and SPD disclosure requirements under ERISA and that "deemed exhaustion" under the ERISA regulations is in effect as a result of CIGNA's actions;





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