UNITED STATES DISTRICT COURT
OF THE WESTERN DISTRICT OF KENTUCKY

Louis Mazzarella, Individually and on Behalf of All Others Similarly Situated

Plaintiff

vs.

Humana, Inc.
500 W. Main Street
Louisville, Kentucky 40202

SERVE: Corporation Service Company
421 W. Main Street
Frankfort, Kentucky 40601

Humana Insurance Company
500 W. Main Street
Louisville, Kentucky 40202

SERVE: Corporation Service Company
421 W. Main Street
Frankfort, Kentucky 40601

and

Humana Pharmacy Solutions, Inc.
500 W. Main Street
Louisville, Kentucky 40202

SERVE: Corporation Service Company
421 W. Main Street
Frankfort, Kentucky 40601

Defendants

Civil No. ______________________

CLASS ACTION

COMPLAINT

Demand for Jury Trial

Plaintiff Louis Mazzarella, by his undersigned attorneys, alleges the following against Defendants Humana Inc. ("Humana"), Humana Insurance Company ("HIC"), and Humana Pharmacy Solutions, Inc. ("HPS"), based upon his knowledge as set forth herein and upon

information and belief. Further additional evidence supporting the claims set forth herein can be obtained after a reasonable opportunity for discovery.

INTRODUCTION

1. Defendant Humana, through its subsidiaries, including, but not limited to, Defendant HIC, provides health insurance throughout the United States. As of December 31, 2015, it had approximately 14.2 million members in medical benefit plans, as well as approximately 7.2 million members in specialty products. Humana was founded in 1961 and is headquartered in Louisville, Kentucky.

2. Plaintiff, who received prescription drug benefits through a health insurance policy issued by Defendants, bring this action on behalf of himself and a class and subclasses of similarly situated persons alleging violations of state law and the Racketeering Influenced and Corrupt Organizations Act ("RICO").

3. Defendants and/or their agents, including, but not limited to, Defendant HPS, required network pharmacies to charge insured patients unauthorized and excessive amounts for prescription drugs. Defendants and/or their agents "clawed back" these excessive payments by forcing the pharmacies to pay the unauthorized and excessive charges to Defendants and/or their agents after collecting them from the insureds.

4. As an example, based on information from one investigation, a member of the Class (defined below) paid a $11.67 "co-payment" to purchase a drug known as codeine and guaifenesin, ***which in fact was a premium of 75% over the actual fee paid by Defendants to the pharmacy***. By way of this unlawful scheme, Defendants and/or their agents contracted with the pharmacy to pay the pharmacy only $6.67 for that prescription. Unknown to and hidden from the Class members at the time, Defendants and/or their agents required the pharmacy to (1) collect the $11.67 "co-payment" from the insured patient, and then (2) pay to Defendants the unlawful

$5.00 "Spread" between the supposed "co-payment" and Defendants' actual cost of the drug. The secret payment of the "Spread" to the Defendants and/or their agents is known as a "Clawback." The transaction is depicted as follows:

Negotiated fee with pharmacy	$	6.67
Co-Payment	$	11.67
Difference Pocketed by Defendants	**$**	**5.00**

Overcharged by 75%

CLAWBACK

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

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

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

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

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

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

JURISDICTION

11. **Subject Matter Jurisdiction.** This court has subject matter jurisdiction over this action pursuant to (a) 28 U.S.C. § 1331, which provides for federal jurisdiction over civil actions arising under the laws of the United States and (b) 18 U.S.C. § 1964 providing for federal jurisdiction to prevent and restrain violations of 18 U.S.C § 1962. Further, this court has supplemental jurisdiction over the state law claims in this action pursuant to 28 U.S.C. 1367. This court also has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332(d) because the matter in controversy exceeds the sum or value of $5,000,000, exclusive of interest and costs, and is a class action of more than 100 members in which a member of the class is a citizen of a State different from any of the Defendants.

12. **Personal Jurisdiction.** This Court has personal jurisdiction over Defendants because a substantial portion of the wrongdoing alleged in this Complaint took place in the State of Kentucky and because Defendants are authorized to and do conduct business in Kentucky and

in this District, have their principal executive offices and provided prescription drug services in Kentucky and in this District, and have advertised, marketed, and promoted their services in this District. Defendants have sufficient minimum contacts with the State of Kentucky and/or otherwise intentionally avail themselves of the markets in the State of Kentucky through the marketing and sale of insurance and related products and services in this State so as to render the exercise of jurisdiction by this Court permissible under traditional notions of fair play and substantial justice.

13. **Venue.** Venue is proper in this Court pursuant to 28 U.S.C. § 1391, because a substantial part of the events giving rise to the claims herein occurred within this District, at least one Defendant resides in this district, and/or a substantial part of property that is the subject of the action is situated in this District.

PARTIES

14. Plaintiff Mazzarella, a resident of Everett, Massachusetts (Middlesex County), is covered by a Humana prescription drug plan with a Medicare contract. Under the policy, Plaintiff was obligated to share the cost for prescription drugs.

15. Defendant Humana is a managed health care holding company with members located throughout the United States. The Company offers coordinated healthcare through health maintenance organizations, preferred provider organizations, point-of-service plans, and administrative services products. Humana offers its products to employer groups, government-sponsored plans, and individuals. Humana is a Delaware corporation with its principal place of business located at 500 West Main Street, Louisville, Kentucky 40202.

16. Defendant HIC, headquartered in Green Bay, Wisconsin, is a wholly-owned subsidiary of Humana through which Humana provides insurance to its members.

17. Defendant Humana Pharmacy Solutions, Inc. is a wholly-owned subsidiary of Humana, with its principal place of business at 500 West Main Street, Louisville, Kentucky 40202. HPS serves as a PBM for millions of individuals throughout the United States. HPS utilizes Argus Health Systems in administering pharmacy benefits. Specifically, Argus provides "the health insurer with pharmacy claims processing, reporting, and other administration services. Argus has been supporting Humana's core pharmacy benefit initiatives, including its Medicare Part D drug benefit strategy, since 2005."[1] On June 18, 2015, it extended its agreement through June of 2020.[2]

SUBSTANTIVE ALLEGATIONS

Health Insurance in General in the United States

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

19. If a health insurance policy covers outpatient prescription drugs, the cost for prescription drugs is often shared between the insured patient and the insurer. Such cost sharing can take the form of deductible payments, co-insurance payments and co-payments. In general,

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[1] PR Newswire, *Argus Heath Systems Renews Pharmacy Administration Services Contract With Humana* (Jun. 18, 2015), http://www.prnewswire.com/news-releases/argus-health-systems-renews-pharmacy-administration-services-contract-with-humana-300101169.html ("Argus Health Systems, a DST company providing pharmacy and health management solutions to key healthcare organizations, today announced a renewal of its contract with Humana Inc. to provide the health insurer with pharmacy claims processing, reporting, and other administration services. Argus has been supporting Humana's core pharmacy benefit initiatives, including its Medicare Part D drug benefit strategy, since 2005. The new agreement will extend the contract through June of 2020. According to Jonathan Boehm, President and CEO of DST's Healthcare segment, Argus is well positioned to help Humana achieve the best possible outcomes for its members.")

[2] *Id.*; *see also* American Pharmacy News, Argus Health renews contract with Humana (Jun. 18, 2015), http://americanpharmacynews.com/stories/510549896-argus-health-renews-contract-with-humana.

deductibles are the dollar amounts the insured pays during the benefit period (usually a year) before the insurer starts to make payments for drug costs. Co-insurance requires an insured person to pay a stated percentage of drug costs, often after exhausting the deductible limit. Co-payments are fixed dollar payments made by an insured patient toward drug costs.

The Pharmacy Benefits Industry and Pharmacy Benefits Managers

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

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

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

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

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

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

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

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

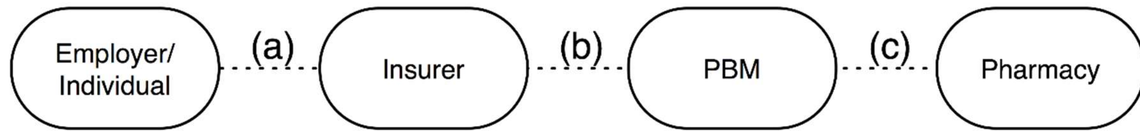
28. This payment of a "Spread" to the insurer and/or its PBM – referred to in the industry as a "Clawback" – evidences the overcharge to the insured.

The Patient–Insurer–PBM–Pharmacy Contractual Relationships

29. Contractual relationships exist between the employer (or individual) and the health insurance company; the health insurance company and the PBM; and the PBM and the pharmacy. As alleged above, an employer buys a health insurance policy from a health insurance company to provide prescription drug benefits for its employees. Health insurance

companies then hire PBMs to manage the prescription drug benefits offered pursuant to their policies.

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

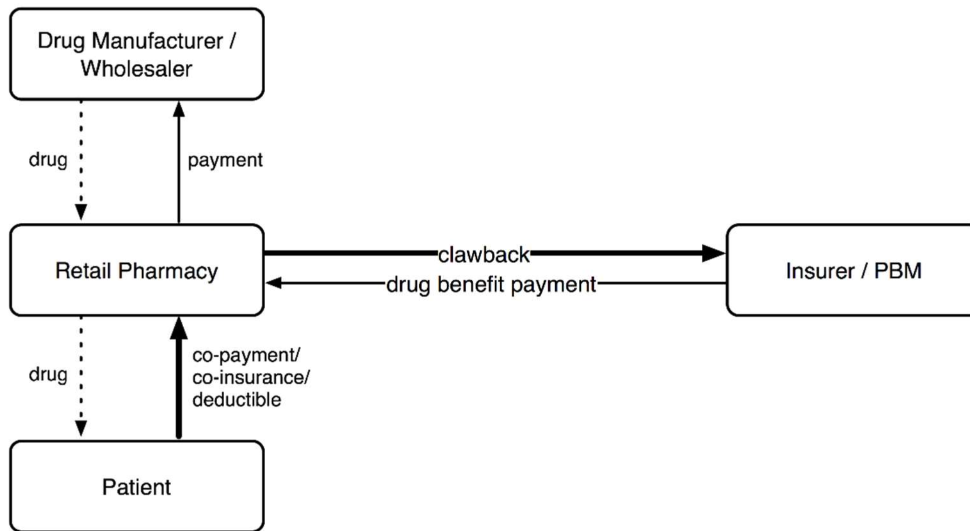


(a) **Employer/Individual–Insurer Agreements (*i.e.*, Insurance Policies).** Employers and individuals buy health insurance policies to provide prescription drug benefits. These policies contain uniform provisions that set forth key plan terms such as the mechanism for and amount of the deductible, co-payment,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

(b) **Insurer–PBM Agreements**. Health insurance companies, such as Defendants, contract with and/or own PBMs, which act as their agents to administer the prescription drug benefits purchased through the health insurance policies that the insurers issue.

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

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



32. Pursuant to the health insurance policies, insurers must ensure that, when they contract with a PBM to act as their agent to manage prescription drug benefits under the health insurance policies, the PBM follows the policies' terms, such that subscribers are not overcharged for their prescription drug benefits.

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

Medicare Prescription Drug Plans

34. In the United States, Medicare is a single-payer, national social insurance program, administered by the U.S. Government since 1966, currently using about 30–50 private insurance companies across the United States under contract for administration. Medicare has four parts: Part A is Hospital Insurance. Part B is Medical Insurance. Part C health plans are branded Medicare Advantage. Part D covers many prescription drugs, though some are covered by Part B.

35. Medicare Prescription Drug Plans ("PDPs") provide pharmacy benefits to their Part D enrollees and serve as middlemen between pharmacies and the plans' members that pay for drug prescriptions. Medicare PDPs contract with the U.S. Government to offer prescription drug benefits along with numerous services, including developing a pharmacy network, formulary design, negotiating drug rebates, drug utilization review, and processing and analyzing prescription claims.

36. In a typical situation, where a benefit plan participant seeks to fill a drug prescription, the role of the Medicare PDP is illustrated as follows: the insured consumer visits a network pharmacy; the pharmacy checks with the Medicare PDP to confirm consumer eligibility, coverage, and copayment information; the consumer pays the copayment (and any deductible) and purchases the drug; the Medicare PDP then reimburses the pharmacy for the remainder of the price negotiated with and set by the government, including the ingredient cost and a dispensing fee less the copayment; and the Medicare PDP then bills the U.S. Government for the payments it made, pursuant to the terms of the contractual agreement between the Medicare PDP and the U.S. Government.

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

37. The Defendants in this case have taken the general insurer-PBM-pharmacy structure and, through various agreements, created their unlawful scheme. Under these agreements, the pharmacy charges the insured patients a prescription drug price that is set by the PBM and/or insurer, which price typically is based on a percentage of the so-called average

wholesale price or "AWP" (the "Insureds' Price").[3] Alternatively, the pharmacy charges the insured patients a co-payment, which also is set by the Defendants and/or their agent PBMs.

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

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

40. In summary, the PBM–Pharmacy Agreements: (1) require pharmacies to charge insureds more for drugs than the Defendants and their PBM pay the pharmacies, with the difference between the two amounts known as the "Spread;" (2) require pharmacies in a Medicare plan to charge more than is permitted pursuant to federal regulations under Medicare; (3) require the pharmacies to collect the "Spread" from patient insureds; (4) require payment of Spread or deduction of the "Spread" from future reimbursement to the pharmacy by the PBM as a "Clawback;" (5) prohibit pharmacies from disclosing to insureds the existence or amount of the "Spread" and "Clawback;" (6) prohibit pharmacies from disclosing to insureds that they can purchase drugs at lower prices; and (7) prohibit pharmacies from selling to insureds covered prescription drugs at prices that are lower than the price that the insurer/PBM orders the pharmacies to charge the insureds. Instead, the "Spread" and "Clawback" overcharges are pocketed secretly and unlawfully by the insurance companies and/or their agents.

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

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

(a) A patient under one of Defendants' health insurance policies went to a pharmacy to purchase chlordiazepoxide HCl and clidinium bromide. Pursuant to federal regulations, a Part D sponsor is required to provide its Part D enrollees with access to **negotiated prices** for covered Part D drugs included in its Part D plan's formulary – which are the amount such pharmacy will receive, **in total**, for a particular drug.

(b) In this documented instance, the total amount paid to the pharmacy (i.e., the negotiated price) was $67.86.

(c) Despite this, the PBM required the pharmacy to charge the insured a $72.86 "co-payment" for the chlordiazepoxide HCl and clidinium bromide, in violation of Defendants' policies and federal regulations. Moreover, the "co-payment" was not a payment made by the insured *in addition* to an amount paid by the insurer and/or PBM for the drug, as the plain meaning of the prefix "co-" required.

(d) The PBM–Pharmacy Agreement then required the pharmacy to pay to the PBM/insurer the "Spread" between the "allowed amount" (or "eligible expenses") and the "co-payment" amount collected from the insured – a $5 "Clawback."

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

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

** PAID CLAIM INFORMATION **

Patient: [redacted]
ADDR:

Drug: CHLORD/CLIDI 5-2.5MG CAP Qty: 90
Cvg: SMD Phone: 800-865-8715

Rx# 1173481 Date: 12-04-15 Trans. Date: 12-04-15 Time: 09:12

	Transmitted	Received	Difference	
Cost	462.85	66.11	396.74	(85.72%)
Fee	15.00	1.75		
Tax		0.00		
Cost+Fee+Tax	477.85	67.86	0.00	Acq Cost
Copay		72.86-		
Amt.Paid		5.00-		

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

43. Upon information and belief, Defendants take Clawbacks and/or Spread payments thousands of time each day from pharmacies all across the country. Additional examples of Defendants clawing back from pharmacies overcharges to Class members include the following:

(a) On November 11, 2015, a Class member paid to a pharmacy a $11.67 copayment for the prescription drug codeine and guaifenesin – ***a 75% premium over the actual $6.67 fee*** paid to the pharmacist. Without disclosing it to the customer, Defendants clawed back the $5 overcharge.

(b) On October 12, 2015, a Class member paid to a pharmacy a $27.45 copayment for the prescription drug phentermine – ***a 22% premium over the actual $22.45 fee*** paid to the pharmacist. Without disclosing it to the customer, Defendants clawed back the $5 overcharge.

The Fox 8 Investigation

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

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

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

47. FOX 8 identified Humana as an offender of this Clawback Scheme.

"Clawbacks" Are Most Common With Widely Used Drugs

48. Defendants impose "Clawbacks" most frequently on widely used, low-cost drugs, and particularly generic drugs, where the cost of the drug is relatively low. This enables Defendants to impose deductible costs, co-payments and co-insurance costs that are higher than the cost of the drug, thereby insuring for themselves a "Clawback." These commonly used drugs include, but are not limited to: promethazine/codeine, feosol, cyclobenzaprine, cyanocobalam, bystolic, folbee, viagra, benzonatate, and metolazone.

Plaintiff's Purchases

49. During the time that Plaintiff was covered by the Defendants' policies, Plaintiff purchased prescriptions drugs for which he was required to share costs, including making

copayments.[4] Upon information and belief based on the fact that Plaintiff purchased drugs for which Defendants overcharge customers, Plaintiff was charged fees for prescription drugs in excess of the fees permitted by his health policy.

50. Plaintiff's purchases of such prescription drugs pursuant to his health insurance policy include, but are not limited to, purchases from Rite Aid Pharmacy in Everett, Massachusetts on the following dates and at the following prices: August 5, 2013-$44.00, September 12, 2013-$44.00, October 18, 2013-$44.00, November 18, 2013-$44.00, December 20, 2013-$44.00, January 27, 2014-$45.00, March 3, 2014-$45.00, April 4, 2014-$45.00, May 6, 2014-$45.00, May 28, 2014-$6.00, June 6, 2014-$45.00, March 25, 2015-$45.00, June 26, 2015- $6.50, August 16, 2015- $6.50, and September 13, 2015- $6.50.

Exhaustion of Administrative Remedies Do Not Apply or Are Futile

51. Plaintiff is not required to exhaust administrative remedies because the injuries to Plaintiff and the Class are part of a nationwide, clandestine, computerized scheme, and any attempt to rectify the harm through administrative means would be futile and unnecessary.

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

53. Making matters worse, on information and belief, Insurer/PBMs contractually bind pharmacies to keep the Clawback Scheme secret and they prevent pharmacies from

[4] For confidentiality reasons, Plaintiff has not specified the drugs he purchased, but if relevant, he will disclose such information during discovery after entry of an appropriate protective order.

informing patients that their drugs could cost less if the pharmacy were permitted to process the purchase outside of the patients' insurance plans. Put differently, if the patient in the chlordiazepoxide HCl and clidinium bromide example above directly asked the pharmacist whether he or she could purchase this drug outside of the insurance (*i.e*., for less than the co-payment), the pharmacy would have been contractually prohibited from disclosing a lower available price or from selling the chlordiazepoxide HCl and clidinium bromide at that lower price – even if the pharmacy could do so at a profit. According to the June 2016 Pharmacy Survey, 39% of respondents answered that these gag-clause restrictions prevented them from informing patients about cheaper options between 10 and 50 times; and 19% of respondents answered that they were prevented by gag-clauses over 50 times from disclosing cheaper alternatives to patients.

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

Plaintiff and the Class Are Entitled to Tolling Due to Fraud or Concealment

55. Plaintiff and the Class Are Entitled to Tolling Due to Fraud or Concealment.

56. By its nature, Defendants' Clawback Scheme has hidden their unlawful conduct from consumers and injured parties.

57. Until recent news broke about Defendants' Clawback Scheme, their unlawful conduct was hidden from Plaintiff and the Class.

58. Even today, the "gag clauses" in place between Defendants and providers continue to hide Defendants' unlawful conduct from members of the Class.

59. To the extent that any of the causes of action alleged *infra* are subject to a specific statute of limitations, Defendants' fraud or concealment alleged herein *tolls* those requirements, for a specific amount of time to be determined as the litigation progresses.

CLASS ACTION ALLEGATIONS

60. Plaintiff bring this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of themselves and the following Class and Subclasses:

> ***RICO Nationwide Class.*** All individuals residing in the United States and its territories who are enrolled in a health benefit plan issued and/or administered by Defendants or their affiliates or insured under Defendants' or their affiliates' health insurance policies, who purchased prescription drugs pursuant to such plans or policies and paid an amount for such drugs that was set by Defendants (or their agents) that was higher than the amount provided by the health insurance plans or policies (the "RICO Class").
>
> ***State Law Nationwide Subclass.*** All individuals residing in the United States and its territories who are enrolled in a health benefit plan not covered by ERISA that is/was issued and/or administered by Defendants or their affiliates or insured under Defendants' or their affiliates' health insurance policies, who purchased prescription drugs pursuant to such plans or policies and paid an amount for such drugs that was set by Defendants (or their agents) that was higher than the amount provided by the health insurance plans or policies (the "State Law Nationwide Subclass").
>
> ***Massachusetts Subclass.*** All individuals residing Massachusetts who are enrolled in a health benefit plan not covered by ERISA that is/was issued and/or administered by Defendants or their affiliates or insured under Defendants' or their affiliates' health insurance policies, who purchased prescription drugs pursuant to such plans or policies and paid an amount for such drugs that was set by Defendants (or their agents) that was higher than the amount provided by the health insurance plans or policies (the "Massachusetts Subclass").

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

67. In the alternative, certification under Rule 23(b)(2) is warranted because Defendant has acted or refused to act on grounds generally applicable to the Class and Subclasses, thereby making appropriate final injunctive, declaratory, or other appropriate equitable relief with respect to each Class and Subclasses as a whole.

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

COUNT I

For Breach of Contract
on Behalf of the State Law Nationwide Subclass

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

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

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

72. Plaintiff Mazzarella and all State Law Nationwide Subclass members purchased the policies that Defendants offered and sold and are either parties to or third-party beneficiaries of such health insurance policies.

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

74. Plaintiff Mazzarella and all State Law Nationwide Subclass members have suffered damages as result of Defendants' breaches.

75. Plaintiff Mazzarella and State Law Nationwide Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT II

For Breach of Contract
on Behalf of the Massachusetts Subclass

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

77. Defendants offered and sold health insurance policies in Massachusetts during the class period alleged herein.

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

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

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

81. Plaintiff Mazzarella, and members of the Massachusetts Subclass, have suffered damages as result of Defendants' breaches.

82. Plaintiff Mazzarella and the Massachusetts Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT III

For Breach of Covenant of Good Faith and Fair Dealing on Behalf of the State Law Nationwide Subclass

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

84. All contracts contain an implied covenant of good faith and fair dealing, including Plaintiff Mazzarella's and the State Law Nationwide Subclass members' contracts with Defendants.

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

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

87. Defendants' performance under the policies deprived Plaintiff Mazzarella and other State Law Nationwide Subclass members of the prescription drug benefits that a reasonable consumer would expect to receive under the policies.

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

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

90. Plaintiff Mazzarella and members of the putative State Law Nationwide Subclass have sustained damages as a result of Defendants' breaches as alleged herein.

91. Plaintiff Mazzarella and the State Law Nationwide Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT IV

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

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

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

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

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

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

97. On information and belief, Defendants' actions as alleged herein were performed in bad faith, in that the purpose behind the practices and policies alleged herein was to maximize Defendants' and/or its agents' revenue at the expense of Plaintiff Mazzarella and the

Massachusetts Subclass members in contravention of the reasonable expectations of Plaintiff and the Massachusetts Subclass members.

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

99. Plaintiff Mazzarella and members of the putative Massachusetts Subclass have sustained damages as a result of Defendants' breaches as alleged herein.

100. Plaintiff Mazzarella and the Massachusetts Subclass are entitled to recover damages and other appropriate relief, as alleged below.

COUNT V

For Unjust Enrichment on Behalf of the State Law Nationwide Subclass

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

102. To the detriment of Plaintiff Mazzarella and members of the State Law Nationwide Subclass, Defendants have been, and continue to be, unjustly enriched by requiring their insureds to pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

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

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

105. Accordingly, Plaintiff Mazzarella and members of the State Law Nationwide Subclass seek full restitution of Defendants' enrichment, benefits and ill-gotten gains acquired as a result of the unlawful and/or wrongful conduct alleged herein.

COUNT VI

**For Unjust Enrichment
on Behalf of the Massachusetts Subclass**

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

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

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

109. Defendants received a benefit from Plaintiff Mazzarella and the Massachusetts Subclass and an inequity results to Plaintiff Mazzarella and the Massachusetts Subclass because of the retention of the benefit by the Defendants.

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

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

COUNT VII

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

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

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

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

115. HPS and all of the pharmacies in the provider network that it manages ("Participating Pharmacies") also are engaged in interstate commerce or in activities that affect interstate commerce.

116. Defendants' scheme to defraud was and is facilitated by the fact that HPS and the Participating Pharmacies are separate legal and distinct entities from Defendants. The scheme relies on the separateness of the health insurer and the PBM and Participating Pharmacies and could not be orchestrated effectively without this legal separateness. As alleged herein, the scheme to defraud Plaintiff and RICO Class members was accomplished pursuant to the various contracts between the health insurer and the policy holder, on the one hand, and the PBM and the Participating Pharmacies, on the other hand. Additionally, the scheme to defraud Plaintiff and RICO Class members was facilitated by HPS's relationship as a PBM with a network of Participating Pharmacies throughout the country from which Plaintiff and RICO Class members obtained prescription drugs pursuant to their health insurance policies.

117. While associated with the Enterprise, each Defendant conducts or participates, directly or indirectly, in the conduct of the Enterprise's affairs through a pattern of racketeering activity. As alleged herein, HPS is a wholly-owned subsidiary of Humana and as such is controlled and managed by Humana. Through its wholly-owned but separate subsidiary, HPS, Defendants have facilitated and/or authorized relationships with Participating Pharmacies that enable the pattern of racketeering activity.

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

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

120. As alleged herein, the plan or scheme to defraud entails: (a) Defendants representing to Plaintiff and Class members through form insurance policy language that they would pay a certain amount for prescription drugs; (b) Defendants entering into agreements with HPS, and HPS, in turn, entering into agreements with Participating Pharmacies, instructing the Participating Pharmacies to overcharge Plaintiff and Class members for prescription drugs; (c) Plaintiff and Class members in fact being overcharged for prescription drugs; and (d) agreements between HPS and Participating Pharmacies prohibiting the disclosure of the unlawful scheme and/or the sale of prescription drugs to Plaintiff and Class members at prices

other than the unlawful prices. As such, the plan was to deprive Plaintiff and Class members of money by deceit and false pretenses, and it was characterized by a departure from community standards of fair play and candid dealings.

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

122. The scheme to defraud consists of Defendants' wrongly depriving Plaintiff and RICO Class members in their property rights by dishonest methods or schemes. Such scheme was willfully devised by Defendants, with each being a knowing and active participant in the

scheme to defraud. Each Defendant specifically intended to commit fraud, and such intent can be inferred from the totality of the allegations herein.

123. The purpose of the scheme was and is to cause Plaintiff and RICO Class members to overpay for their prescription drugs so that the overcharge would be clawed back by HPS and then incorporated into Humana's financials.

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

125. On or about the dates set forth below, Defendants unlawfully, willfully, and knowingly, having devised and intending to devise a scheme and artifice to defraud by obtaining money and property by means of false and fraudulent pretenses, representations, and promises,

transmitted and caused to be transmitted by means of wire communication in interstate commerce, writings, signs, signals, pictures, and sounds, for the purpose of executing such scheme and artifice.

126. For example, when Plaintiff Mazzarella purchased prescriptions drugs, Defendants caused to be transmitted mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on at least the following dates as further alleged above.

127. On or about these dates, Rite Aid Pharmacy, located in Everett, Massachusetts, sent and received mail, interstate messages or deliveries and/or wire transmissions in connection with (a) determining whether the Plaintiff and the prescription drugs were covered under their health insurance policies and how much Plaintiff should pay for the drugs; (b) processing Plaintiff's payments for such prescription drugs; and (c) processing the PBM's payments to and/or Clawback from the pharmacies.

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

PRAYER FOR RELIEF

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

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

B. Finding that Defendants denied Plaintiff, the Class, and Subclasses benefits and their rights under the policies and awarding such relief as the Court deems proper;

C. Finding that Plaintiff, the Class, and Subclasses are entitled to clarification of the rights under the policies and awarding such relief as the Court deems proper;

D. A declaration that Defendants' actions, as described herein, violate the federal and state laws and legal standards invoked herein;

E. An award of preliminary and permanent injunctive and other equitable relief as is necessary to protect the interests of Plaintiff, the Class, and Subclasses and permitted by the above claims, including, inter alia, an order prohibiting Defendants from engaging in the unlawful act described above, an order invalidating Defendants' "gag clauses" with pharmacies and pharmacists, and/or an order requiring Defendants or their agents to disclose the true price of the drug and whether it would be cheaper to purchase the drug without using health benefits managed and administered by Defendants;

F. Awarding Plaintiff, the Class, and Subclasses damages as deemed appropriate by the Court;

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

H. An award to Plaintiff, the Class, and Subclasses of restitution and/or other equitable relief, including, without limitation, disgorgement of all profits and unjust enrichment that Defendants obtained from Plaintiff and the Class as a result of its unlawful, unfair and fraudulent business practices described herein;

I. Awarding Plaintiff's counsel attorneys' fees, litigation expenses, expert witness fees and other costs pursuant to the common fund doctrine;

J. Awarding Plaintiff, the Class, and Subclasses their reasonable costs and expenses incurred in this action, including counsel fees and expert fees;

K. For an order that Defendants must notify each and every individual who paid a copayment or coinsurance for covered prescription drugs that exceeded the true cost of the drug about the pendency of this action so that they may obtain relief from Defendants for their harm; and

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

JURY TRIAL DEMANDED

Plaintiff hereby demands a trial by jury.

Dated: December 29, 2016

Respectfully submitted,

s/ Jacob Levy

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Attorneys for Plaintiff

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
Louis Mazzarella

(b) County of Residence of First Listed Plaintiff: Middlesex, Massachusetts
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Gray & White
713 E. Market St. #200, Louisville, Ky 40202
(502) 805-1800

DEFENDANTS
Humana, Inc., Humana Insurance Company, and Humana Pharmacy Solutions, Inc.

County of Residence of First Listed Defendant ____
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ❒ 1 U.S. Government Plaintiff
- ❒ 3 Federal Question *(U.S. Government Not a Party)*
- ❒ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	❒ 1	❒ 1	Incorporated *or* Principal Place of Business In This State	❒ 4	☒ 4
Citizen of Another State	☒ 2	❒ 2	Incorporated *and* Principal Place of Business In Another State	❒ 5	❒ 5
Citizen or Subject of a Foreign Country	❒ 3	❒ 3	Foreign Nation	❒ 6	❒ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ❒ 110 Insurance
- ❒ 120 Marine
- ❒ 130 Miller Act
- ❒ 140 Negotiable Instrument
- ❒ 150 Recovery of Overpayment & Enforcement of Judgment
- ❒ 151 Medicare Act
- ❒ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ❒ 153 Recovery of Overpayment of Veteran's Benefits
- ❒ 160 Stockholders' Suits
- ❒ 190 Other Contract
- ❒ 195 Contract Product Liability
- ❒ 196 Franchise

REAL PROPERTY
- ❒ 210 Land Condemnation
- ❒ 220 Foreclosure
- ❒ 230 Rent Lease & Ejectment
- ❒ 240 Torts to Land
- ❒ 245 Tort Product Liability
- ❒ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ❒ 310 Airplane
- ❒ 315 Airplane Product Liability
- ❒ 320 Assault, Libel & Slander
- ❒ 330 Federal Employers' Liability
- ❒ 340 Marine
- ❒ 345 Marine Product Liability
- ❒ 350 Motor Vehicle
- ❒ 355 Motor Vehicle Product Liability
- ❒ 360 Other Personal Injury
- ❒ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ❒ 365 Personal Injury - Product Liability
- ❒ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ❒ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ❒ 370 Other Fraud
- ❒ 371 Truth in Lending
- ❒ 380 Other Personal Property Damage
- ❒ 385 Property Damage Product Liability

CIVIL RIGHTS
- ❒ 440 Other Civil Rights
- ❒ 441 Voting
- ❒ 442 Employment
- ❒ 443 Housing/ Accommodations
- ❒ 445 Amer. w/Disabilities - Employment
- ❒ 446 Amer. w/Disabilities - Other
- ❒ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ❒ 463 Alien Detainee
- ❒ 510 Motions to Vacate Sentence
- ❒ 530 General
- ❒ 535 Death Penalty

Other:
- ❒ 540 Mandamus & Other
- ❒ 550 Civil Rights
- ❒ 555 Prison Condition
- ❒ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ❒ 625 Drug Related Seizure of Property 21 USC 881
- ❒ 690 Other

LABOR
- ❒ 710 Fair Labor Standards Act
- ❒ 720 Labor/Management Relations
- ❒ 740 Railway Labor Act
- ❒ 751 Family and Medical Leave Act
- ❒ 790 Other Labor Litigation
- ❒ 791 Employee Retirement Income Security Act

IMMIGRATION
- ❒ 462 Naturalization Application
- ❒ 465 Other Immigration Actions

BANKRUPTCY
- ❒ 422 Appeal 28 USC 158
- ❒ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ❒ 820 Copyrights
- ❒ 830 Patent
- ❒ 840 Trademark

SOCIAL SECURITY
- ❒ 861 HIA (1395ff)
- ❒ 862 Black Lung (923)
- ❒ 863 DIWC/DIWW (405(g))
- ❒ 864 SSID Title XVI
- ❒ 865 RSI (405(g))

FEDERAL TAX SUITS
- ❒ 870 Taxes (U.S. Plaintiff or Defendant)
- ❒ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ❒ 375 False Claims Act
- ❒ 400 State Reapportionment
- ❒ 410 Antitrust
- ❒ 430 Banks and Banking
- ❒ 450 Commerce
- ❒ 460 Deportation
- ☒ 470 Racketeer Influenced and Corrupt Organizations
- ❒ 480 Consumer Credit
- ❒ 490 Cable/Sat TV
- ❒ 850 Securities/Commodities/ Exchange
- ❒ 890 Other Statutory Actions
- ❒ 891 Agricultural Acts
- ❒ 893 Environmental Matters
- ❒ 895 Freedom of Information Act
- ❒ 896 Arbitration
- ❒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ❒ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ❒ 2 Removed from State Court ❒ 3 Remanded from Appellate Court ❒ 4 Reinstated or Reopened ❒ 5 Transferred from Another District *(specify)* ❒ 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. 1332

Brief description of cause:
RICO Cause of action

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ❒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE ____ DOCKET NUMBER ____

DATE: 12/29/2016
SIGNATURE OF ATTORNEY OF RECORD: /s/ Jacob Levy

FOR OFFICE USE ONLY

RECEIPT # ____ AMOUNT ____ APPLYING IFP ____ JUDGE ____ MAG. JUDGE ____