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Clerk
Marion County, Indiana

STATE OF INDIANA	)	IN THE MARION CIRCUIT/SUPERIOR COURT
	) SS:	
COUNTY OF MARION	)	CAUSE NO. _____

HENRY BITTMANN, Derivatively on Behalf of Nominal Defendant ANTHEM, INC., Plaintiff, v. JOSEPH R. SWEDISH, WAYNE S. DEVEYDT, THOMAS C. ZIELINSKI, ELIZABETH E. TALLETT, GEORGE A. SCHAEFER, JR., R. KERRY CLARK, ROBERT L. DIXON, JR., LEWIS HAY, III, JULIE A. HILL, RAMIRO G. PERU, and WILLIAM J. RYAN, Defendants, - and - ANTHEM, INC. Nominal Defendant.	)	**JURY TRIAL REQUESTED**

VERIFIED STOCKHOLDER DERIVATIVE COMPLAINT

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Plaintiff Henry Bittmann ("Bittmann" or "Plaintiff"), by and through his undersigned counsel, brings this action derivatively on behalf of Nominal Defendant Anthem, Inc. ("Anthem" or the "Company") against certain current and former members of Anthem's board of directors (the "Director Defendants") and executive officers ("Officer Defendants" and together, with the Director Defendants, "Individual Defendants"), seeking to remedy breaches of fiduciary duties, unjust enrichment, and corporate waste, from at least January 1, 2014 through the present (the "Relevant Period"). Plaintiff makes these allegations upon personal knowledge, as to the facts of his ownership of Anthem stock, and upon information and belief, as to all other matters, based upon an in-depth review of: (a) public filings made by Anthem and other related parties and non-parties with the U.S. Securities and Exchange Commission ("SEC"); (b) press releases and other publications disseminated by the Company and other related non-parties; (c) news articles, shareholder communications, and postings on Anthem's website concerning the Company's public statements; (e) the proceedings in an action in the Delaware Court of Chancery between Cigna Corporation ("Cigna") and Anthem, captioned *Cigna Corp. v. Anthem, Inc.*, C.A. No. 2017-0109-JTL (Del. Ch.); (d) the proceedings, court opinions, and documents filed in the federal antitrust action brought by the U.S. Department of Justice ("DOJ") and several states' attorneys general, captioned *United States v. Anthem, Inc.*, No. 1:16-cv-01493 (D.D.C.) (the "DOJ Action"); and (e) other publically available information concerning Anthem and the Defendants.

I. NATURE OF THE ACTION

1. Anthem and Cigna are, respectively, the second and third largest health insurers in the Country. They represent two opposite business models in the industry, and they are also often each other's fiercest competitors. This case is about how Anthem sought to improperly fulfill its quest to make sure Cigna "***does not exist***" by way of selling an acquisition of the latter

as a means to increase competition when, in reality, Anthem wanted to do the opposite, how regulators and courts blocked that effort, and how Anthem suffered the resulting damage in the aftermath. [Emphasis added]. But all these damages could have been avoided if Anthem's officers had not violated their fiduciary duties to the Company by seeking to violate the antitrust laws by pushing for an anticompetitive merger, and if Anthem's board of directors (the "Board") had not violated their fiduciary duties, and thus committed willful misconduct, by actively speeding along the process instead of acting in good faith to prevent this merger from being approved. This action to recover damages to the Company from Defendants' (defined below) breaches of fiduciary duty follows.

2. Anthem is the largest member of the Blue Cross Blue Shield Association ("BCBSA"), and its membership gives it access to the BCBSA's provider network that includes more than 90% of the nation's physicians and hospitals, as well as the BCBSA's collective membership of over 100 million insured. The access to these massive networks allows Anthem to conduct business based on the traditional model of driving revenues by keeping costs low while maintaining a high volume, and thus, Anthem is known as the "Wal-Mart" of health insurance. It keeps costs low by giving low reimbursements to providers, who are willing to accept Anthem's low rates because Anthem is able to offer them many potential patients through the BCBSA's network of the insured. And in turn, because it is able to keep reimbursements low, Anthem is able to offer its customers steep provider discounts. Coupled with the ability to offer access to the BCBSA's extensive provider network, this makes Anthem ideally suited to selling administrative services only ("ASO") plans to large employers who need nationwide coverage, also called "national accounts."

3. Anthem is one health insurance leader in the "national accounts" market; Cigna is the other. Cigna, being only half Anthem's size in total revenue, offers a different approach to healthcare: it seeks to keep healthcare costs low by giving financial incentives to its insured to live healthier lifestyles, or "wellness programs," and gives providers financial incentives to encourage their insured to live healthier lifestyles, use fewer medical services, and engage in preventive care – an approach known as "provider collaboration." Cigna is thus known as the "innovator" and "maverick" in health insurance, and it has achieved rapid growth and financial success as a result. While it is not able to offer the steep discounts of Anthem, it is able to offer value by its approach to keep healthcare costs low and, as such, competes head to head with Anthem in "national accounts" and other markets.

4. Cigna's innovations have spurred Anthem, as well as other health insurers, to also innovate, in that now, all health insurers seek to increase "provider collaboration" and otherwise offer "value" over "volume." This innovation, in turn, has increased consumer welfare by offering better, more cost-effective health insurance options to all customers.

5. Anthem's initial approach to Cigna's "competitive threat" was to try to "bury" it by beating Cigna on price by, among other things, offering zero-percent "trend guarantees" that sought to reduce cost increases for its customers. At the same time, Anthem sought to take a more direct approach to eliminating Cigna as a competitor – by buying it. Thus, Anthem's officers began to engage in merger discussions with Cigna in mid-2014 (the "Merger").

6. However, Anthem's officers discovered what they described as an "***insurmountable barrier***" to a transaction: restrictions Anthem faced by its membership in the BCBSA that curbed the revenues it could obtain from non-Blue Cross Blue Shield business, at one-third of Anthem's total revenues, which would be difficult or impossible to achieve given

Cigna's large volume of business, unless Anthem were to "rebrand" much of Cigna's business into Anthem's BCBSA-branded business, which, in turn, would destroy the distinctive value proposition of Cigna. Anthem's officers told Anthem's board of directors about this problem, and they in turn called off the Merger talks in February 2015.

7. Yet, mere months later, Anthem's officers and Board restarted those talks, because they were worried that Anthem would be left behind as market rumors of a major health insurance merger involving the nation's fifth largest insurer, Humana, Inc. ("Humana"), meant the industry was rapidly consolidating. As Anthem's then-Chief Executive Officer ("CEO"), Defendant Joseph R. Swedish ("Swedish"), put it, he did not want Anthem to become the "American Motors" of healthcare insurance (*i.e.*, a former large player in its industry who has since been extinguished): he wanted Anthem to be like "***one of the big three autos***." [Emphasis added].

8. As such, in May 2015, Anthem's Board and officers again commenced Merger negotiations with Cigna. When Cigna expressed concerns that the BCBSA's rules would prove to be an impediment, Anthem's officers re-assured Cigna that they had "many levers" to adapt to those rules. Anthem's officers also publicly sold the deal as spurring innovation while minimizing the risks to regulatory approval, despite their knowledge that the BCBSA's rules would force Anthem to convert Cigna members to the BCBSA brand, thus eliminating, rather than promoting, competition, which would lead to almost certain failure to pass regulatory scrutiny since the BCBSA, at that very moment, was subject to an antitrust lawsuit with those very rules at issue.

9. The Board, instead of checking their officers in what was clearly an attempt to steamroll through the Merger in violation of the antitrust laws, either winked-and-nodded or

were willfully blind as to the risk. The directors' discussions of the Merger negotiations, as revealed in public filings, covered almost every issue ***except*** the BCBSA issues that mere months earlier were a show-stopper to the negotiations with the same counterparty.

10. In any event, by concealing the risks from the public and Cigna, Anthem's officers and directors were able to sell Cigna on the deal, and Anthem's shareholders to approve a stock issuance that would help effectuate the deal. But regulators were not convinced and commenced an 11-month investigation soon after the Anthem-Cigna merger agreement (the "Merger Agreement") was entered. In July 2016, the DOJ and several states sued Anthem and Cigna to enjoin the Merger, the U.S. District Court for the District of Columbia (the "District Court") found that the proposed Merger was anticompetitive and granted the injunction, and the injunction was upheld on appeal in what the U.S. Court of Appeals of the District of Columbia (the "Appeals Court") described as "***not a close case.***" Shortly afterwards, the parties terminated the Merger Agreement. Since then, Cigna has been locked in bitter litigation against Anthem, seeking to recover a $1.85 billion reverse regulatory termination fee, as well as a total of $13 billion in damages that includes Cigna's estimate of the lost value of the deal, in what Cigna alleges was a willful breach of the Merger Agreement by Anthem. [Emphasis added].

II. JURISDICTION AND VENUE

11. The Court has jurisdiction over this civil matter because, under Ind. Code §§ 33-28-1-2 and 33-29-1-1.5, circuit and superior courts have "original and concurrent jurisdiction in all civil cases[.]"

12. Venue is proper in this Court because the Nominal Defendant is an Indiana corporation.

13. Venue is also proper in this Court, and the Court has personal jurisdiction over the Defendants, because the Director and Officer Defendants agree to be bound by Marion County

Superior Court, as Title XI, Section 11.1, of Anthem's Bylaws specify that "the sole and exclusive forum for" derivative and breach of fiduciary duty suits "shall be, to the fullest extent permitted by law, the Marion Superior Court (Marion County, Indiana)."

III. PARTIES

A. Plaintiff

14. Plaintiff Bittmann is a shareholder of Anthem, has continuously held his shares at all times relevant hereto, and will continue to hold Anthem shares throughout the pendency of this action. Plaintiff will fairly and adequately represent the interests of shareholders in enforcing the rights of the Company.

B. Nominal Defendant

15. Nominal Defendant Anthem is an Indiana corporation with its principal executive offices located at 120 Monument Circle, Indianapolis, Indiana 46204. Anthem is the second largest health insurance company in the United States by enrollment, serving 38.6 million members at the end of 2015 and around 40 million members currently. Through its affiliates, Anthem services over 70 million individuals in total. The Company's operating revenues are around $85 billion per year and profits are around $2 to $3 billion per year. Anthem is also the largest member of the BCBSA (collectively, with other members, which consists of 36 companies in all, including Anthem, the "Blues"), and services 28.6 million BCBSA members. The Company's main competitors are UnitedHealthCare, Inc. ("United"), Aetna, Inc. ("Aetna"), and Cigna.

16. Anthem is the exclusive Blue Cross Blue Shield licensee for parts of or all of 14 states, including Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, most of Missouri, Nevada, New Hampshire, parts of New York, Ohio, most of Virginia, Wisconsin, and is the Blue Cross licensee for California. The Company also arranges to conduct business through

arrangements with Blue Cross Blue Shield licensees in South Carolina and Texas. In addition, Anthem competes as a non-Blue through its subsidiaries: (1) Amerigroup Corporation ("Amerigroup") in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington; (2) CareMore Health Group, Inc. ("CareMore") in parts of Arizona, California, Nevada, New York, and Virginia; (3) Simply Healthcare Holdings, Inc. ("Simply Healthcare") in Florida; and (4) HealthLink, Inc. and UniCare Life & Health Insurance Company ("UniCare") throughout the Country. Through its subsidiaries, Anthem is licensed to conduct business in all 50 states. Moreover, its membership in the BCBSA gives it access to all Blue providers and members.

C. Director Defendants

17. Defendant Elizabeth E. Tallett ("Tallett") has been a director of the Board since October 2013 and Chair of the Board since May 16, 2018.

18. Defendant George A. Schaefer, Jr. ("Schaefer") has been a director of the Board since 2001 and was Chair of the Board from May 2013 through November 2017.

19. Defendant R. Kerry Clark ("Clark") has been a director of the Board since May 2014.

20. Defendant Robert L. Dixon, Jr. ("Dixon") has been a director of the Board since July 2011.

21. Defendant Lewis Hay, III ("Hay") has been a director of the Board since July 2013.

22. Defendant Julie A. Hill ("Hill") has been a director of the Board since November 2004.

23. Defendant Ramiro G. Peru ("Peru") has been a director of the Board since November 2004.

D. Officer Defendants

24. Defendant William J. Ryan ("Ryan") was a director of the Board from 2001 until May 18, 2017.

25. Defendant Swedish was a director of the Board from March 2013 through May 16, 2018, and served as President and CEO of Anthem from March 2013 to November 2017. Non-Party Gail K. Boudreaux then succeeded him as President and CEO, when he was promoted to Executive Chair and served as such until May 16, 2018. As of May 16, 2018, Swedish retired from the Board, as well as from officer positions, but continues to be retained in a paid position as Senior Advisor to the Board.

26. Defendant Wayne S. DeVeydt ("DeVeydt") was Executive Vice President and Chief Financial Officer ("CFO") of Anthem from 2007 through May 31, 2016.

27. Defendant Thomas C. Zielinksi ("Zielinksi") has served as Executive Vice President and General Counsel of Anthem since 2014.

28. Defendants Tallett, Schaefer, Clark, Dixon, Hay, Hill, Peru, Ryan, and Swedish, who consist of current and former directors, are collectively referred to herein as the "Director Defendants."

29. Defendants Swedish, DeVeydt, and Zielinksi are collectively referred to herein as the "Officer Defendants."

30. The Director and Officer Defendants are collectively referred to herein as the "Individual Defendants." Anthem and the Individual Defendants are collectively referred to herein as the "Defendants."

E. Relevant Non-Parties

31. Cigna is a Delaware corporation with its principal executive offices located in Bloomfield, Connecticut, and Philadelphia, Pennsylvania. Cigna is the third largest health

insurance company in the United States and has experienced rapid growth through its focus on innovation and provider collaboration. It services over 15 million members throughout the United States, Canada, Europe, the Middle East, and Asia, with 13 million members in the United States alone. Cigna's annual revenues are around $39 billion per year and its net operating income is around $2 billion per year. Cigna's business model seeks to steer away from the usual health insurance model of lowering provider reimbursements and, instead, focuses on reducing healthcare costs through increasing wellness among members and collaboration with providers by paying them based on quality of care rather than merely quantity of services.

32. David Cordani ("Cordani") has been the President and CEO of Cigna since 2009. He was extensively involved in negotiating the Merger with Swedish, supposed to be co-lead of the integration efforts, and supposed to take the role of President and Chief Operating Officer ("COO") in the combined company. Cordani was initially an enthusiastic supporter of the proposed Merger between Anthem and Cigna and developed an argument about Cigna and Anthem being complements of each other, which helped bolster the case that the Merger was pro-competitive. But, as the integration process went on from late 2015 through early 2016, Cordani felt increasingly sidelined by Swedish and other Anthem executives and became less supportive of the Merger – especially Swedish and Anthem's take on it.

33. Gail K. Boudreaux ("Boudreaux") has been a director of the Company since November 2017, when she succeeded Swedish as the President and CEO (Swedish then became her supervisor after his ascension to Executive Chair). Before joining Anthem, Boudreaux was CEO of GKB Global Health LLC, a health care strategy and business advisory firm, from July 2013 to November 2017. Before then, she was Executive Vice President of United from May 2008 to February 2015, President of United Healthcare, its subsidiary, from May 2008 to January

2011, and United's CEO from January 2011 to November 2014. Before then, she was Executive Vice President of External Operations at Health Care Services Corporation ("HCSC") – the second largest Blue – and she was President of Blue Cross Blue Shield of Illinois from 2002 to 2005 (one of HCSC's plans). Before joining HCSC, Boudreaux held various leadership positions at Aetna, including Senior Vice President, Group Insurance. She has been a director of Biomet Holdings, Inc., a medical device company, since 2012. Boudreaux also serves as a director of the BCBSA, as well as a director of the National Institute for Health Care Management, Health Services Foundation, Dartmouth College Board of Trustees, the Central Indiana Corporate Partnership, and is a member of the Business Roundtable.

34. Bahjia Jallal ("Jallal") has been a director of the Company since February 2018. She has worked in the healthcare industry at least since 2006. Jallal joined Medimmune, Inc., a biotechnology firm, in 2006 and has been its President since January 2013. She has served as Executive Vice President of AstraZeneca PLC, a pharmaceutical and biopharmaceutical business, since January 2013. Jallal has also been President of the Board of the Association for Women in Science since 2016 and a member of the Board of Trustees of Johns Hopkins University since 2014.

35. Antonio F. Neri ("Neri") has been a director of the Company since December 2017. Neri has served as President and CEO of Hewlett Packard Enterprise Company since February 2018, and before then, he served in a variety of leadership roles in that company or its predecessors since 1995.

IV. THE INDIVIDUAL DEFENDANTS' DUTIES AND OBLIGATIONS

36. Anthem's Bylaws, Articles of Incorporation, Corporate Governance Guidelines, and Standards of Ethical Business Conduct (the "Code of Conduct") specifically set forth the

duties and obligations that Anthem Board members and/or officers are required to fulfill on behalf of the Company.

37. Section 6.4 of Anthem's Articles of Incorporation command Anthem's directors to "discharg[e] [their] duties . . . in good faith, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, and in a manner the Director reasonably believes to be in the best interests of the Corporation[.]" While a director is entitled to rely on information prepared by counsel or by officers, such reliance "is not . . . in good faith if the Director has knowledge concerning the matter in question that makes reliance . . . unwarranted." Furthermore, a director is liable for actions or failures to take actions that are in violation of their duties under Section 6.4 and "the breach or failure to perform constitutes willful misconduct or recklessness."

38. Anthem's Corporate Governance Guidelines provide that "[e]veryone is expected to act in accordance with" Anthem's Code of Conduct.

39. The Code of Conduct "applies to Anthem, Inc., its affiliates and subsidiaries, Board of Directors, officers, management and associates" and enjoins them to be "responsible for knowing, understanding, and complying with [Anthem's] policies and applicable laws." The Code of Conduct also specifically calls for "compl[iance] with applicable antitrust laws."

40. By reason of their positions as directors and fiduciaries of Anthem, and by virtue of their ability to control the business and corporate affairs of the Company, each of the Individual Defendants owed, and as to current directors, owes, Anthem and its shareholders the fiduciary obligations of loyalty, good faith, and candor and were, and are, required to use their utmost ability to control and manage the Company in a lawful, fair, just, honest, and equitable manner. The Director Defendants were, and are, required to act in furtherance of the best

interests of Anthem and its shareholders, so as to benefit all shareholders equally and not in furtherance of their personal interest or benefit.

41. Each Individual Defendant owes to Anthem and its shareholders the fiduciary duty to exercise good faith and diligence in the administration of the affairs of the Company, use and preservation of its property and assets, and highest obligations of fair dealing.

42. At all times relevant hereto, each Individual Defendant was the agent of each of the other Individual Defendants, and of the Company, and was, at all times, acting within the course and scope of such agency.

43. By virtue of their fiduciary duties of loyalty, good faith, and candor, each Individual Defendant was required to, among other things:

a. exercise good faith to ensure that Anthem's affairs were conducted in an efficient, business-like manner;

b. exercise good faith to ensure that the Company was operated in a diligent, honest, and prudent manner and complied with all applicable federal and state laws, rules, regulations, requirements, and all contractual obligations, including acting only within the scope of its legal authority;

c. when put on notice of problems with the Company's business practices and operations, exercise good faith in taking appropriate action to correct the misconduct and prevent its recurrence;

d. remain informed as to how the Company conducted its operations, and upon receipt of notice or information of imprudent or unsound conditions or practices, make reasonable inquiry in connection therewith; and

e. refrain from causing the Company to engage in unlawful activity.

44. The Individual Defendants committed willful misconduct by knowingly or consciously breaching their fiduciary duties of loyalty and good faith. They did so by causing themselves, or allowing other Individual Defendants to cause Anthem, to engage in unlawful activity by:

a. pursuing the Merger with the purpose and effect, if consummated, of stifling competition, in violation of the antitrust laws;

b. issuing material misstatements or omissions in filings with the SEC that had the purpose and effect of misleading Anthem stockholders to approve the stock issuance for the purpose of effectuating the Merger; and

c. making material misstatements or omissions in public statements to investors and the government, as well as non-public statements to the government and to Cigna, for the purpose of misleading them into thinking the Merger would be procompetitive.

45. This misconduct has caused Anthem to be damaged both financially and reputationally.

46. Furthermore, by virtue of their positions of control and authority as directors and/or officers of Anthem, the Individual Defendants were able to and did, directly or indirectly, exercise control over the wrongful acts complained of herein. The Individual Defendants also failed to prevent other of the Individual Defendants from engaging in misconduct.

V. SUBSTANTIVE ALLEGATIONS

A. The DOJ and Federal Trade Commission Enforce Antitrust Laws to Protect Competition and Issue Guidelines to Help Companies Comply

47. Both the federal and state governments have antitrust laws that help ensure a competitive marketplace. The main federal antitrust statutes are the Sherman Act, 15 U.S.C.

§§1-7, the Clayton Act, 15 U.S.C. §§12-27, and parts of the Federal Trade Commission Act, 15 U.S.C. §45. The DOJ and Federal Trade Commission ("FTC") are charged with enforcing the federal antitrust laws, while the various state attorneys general are charged with enforcing the state antitrust laws.

48. The DOJ and FTC can sue to enjoin mergers that violate §7 of the Clayton Act, 15 U.S.C. §18, which prohibits mergers or acquisitions "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition[.]"

49. In the context of assisting merging companies with complying with the antitrust laws, the DOJ and FTC have jointly published the Horizontal Merger Guidelines (the "Guidelines"). The Guidelines have a "unifying theme . . . that mergers should not be permitted to create, enhance, or entrench market power to facilitate their exercise."

50. The Guidelines note that "[a] merger can enhance market power simply by eliminating competition between the merging parties. . . . A merger also can enhance market power by increasing the risk of coordinated, accommodating, or interdependent behavior among rivals."

51. The Guidelines emphasize that "[t]he elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition." And while this may be "most apparent in a merger to monopoly," it is "by no means limited to that case."

52. One of the concerns the Guidelines have with eliminating competition through a merger is whether it "is likely to diminish innovation competition by encouraging the merged firm to curtail its innovative efforts below the level that would prevail in the absence of the

merger." This "curtailment of innovation could take the form of . . . reduced incentive to initiate the development of new products."

53. Nevertheless, one defense to an otherwise anticompetitive merger the Guidelines recognize is a merger's "potential to generate significant efficiencies[.]" However, the Guidelines "credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of . . . the proposed merger[,]" *i.e.*, "merger-specific efficiencies." The Guidelines caution, "Efficiencies will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means." Thus, the merger-specific efficiencies the Guidelines recognize are "verified and do not arise from anticompetitive reductions in output or service." Furthermore, "[e]efficiencies almost never justify a merger to monopoly or near-monopoly."

B. The Blues' History and Rules Illustrate Their Anticompetitive Purpose

54. The Blues, collectively, are by far the most extensive health insurance companies in the Country; they provide healthcare coverage for around 105 million people in the United States; and they have the most extensive provider networks in the Country, with over 95% of professional providers and 96% of hospitals having contracts with the Blues. Ostensibly, each Blue is an independent health insurance company.

55. Nominally, the purpose of the BCBSA is to regulate the use of the Blue Cross Blue Shield service marks. However, in reality, as its history and rules reveal, the BCBSA serves as a coordinating council for a cartel to curtail competition, as alleged in a long-running multidistrict antitrust litigation, captioned *In re: Blue Cross Blue Shield Antitrust Litig.*, MDL No. 2406, Civil Action No. 2:12-cv-02532 (N.D. Al.) (the "MDL Action").

56. When they were initially created, Blue Cross and Blue Shield plans served different needs: Blue Cross plans covered the cost of hospital care while Blue Shield plans

covered physician care. The plans were run by independent nonprofit entities, and Blue Cross and Blue Shield plans regularly competed with each other. But throughout the 1940s through the 1980s, Blue Cross and Blue Shield plans slowly consolidated, until, by 1982, the Blue Cross Association and Blue Shield Association merged into the BCBSA.

57. Shortly after its creation, in November 1982, the BCBSA implemented a "Long-Term Business Strategy" (the "Strategy"), which its primary proponent described to the BCBSA board as a "fundamental change" that would result in "***a concentration of power***." [Emphasis added].

58. The Strategy operated to reduce competition among the Blues through several "propositions." Proposition 1.1 required all Blue Cross and Blue Shield plans to become joint Blue Cross Blue Shield plans by the end of 1984, unless the BCBSA board granted an exemption. Proposition 1.2 mandated that only one Blue plan could operate per state by the end of 1985, unless the BCBSA board granted an exemption. The implementation of Propositions 1.1 and 1.2 had the effect of dramatically reducing the number of Blues from 114 in 1984, to 75 in 1989, to 36 currently. Blue Cross and Blue Shield plans also stopped competing with each other in most states.

59. The Strategy also specifically sought to increase revenues by reducing reimbursements to providers. Proposition 3.4 called for "an intensified program to retain, acquire and expand provider and professional payment differentials[,]" *i.e.*, the difference between what healthcare providers billed and what the Blues paid to them.

60. Furthermore, the BCBSA issued a white paper on April 4, 1987, to provide further recommendations on "when it might be in a Plan's self-interest to forego some of its prerogatives in the name of the 'system' or to promote a common purpose." The white paper

recommended the exclusive use of the Blue service marks within each plan's service areas, though it recognized that exclusive service areas were not necessary to preserve the marks and that exclusivity would be subject to antitrust challenges. However, internal meetings regarding the White Paper specified that the advantage of exclusive service areas was to "eliminate competition from other Blue Plans." These exclusive areas create "[l]arger market share because other Blues stay out and do not fragment the market." By 1990, the BCBSA approved new licensing agreements that specified the Blue Cross Blue Shield name and marks would be tied to membership in the BCBSA, and these licensing agreements also led to establishing exclusive service areas. With limited exceptions, only one Blue is allowed to use BCBSA marks or market BCBSA-branded products in each service area. No Blue may solicit business using Blue brands outside its designated service area, unless the holder of a Blue license in that area "cedes" the right to another plan. Once a plan "cedes" to another plan, they are not in competition because the ceding plan forfeits the right to bid on the ceded account.

61. While the licensing agreements and membership requirements eliminated Blue on Blue plan competition within any given territory, competition by non-Blue subsidiaries increased. By 1991, these non-Blue subsidiaries, providing non-Blue competition in Blue areas, had mushroomed from 50 to 60 to over 400. The BCBSA then developed rules that eventually took the form of the "Best Efforts Rules" ("BCBSA's rules" or the "Rules") of today, which vastly reduced the non-Blue competition among the Blues.

62. The Rules and attendant membership standards and licensing agreements reduced non-Blue competition by specifying that each Blue would derive ***80%*** of its and its subsidiaries' annual revenue from its designated service area and ***66.66%*** of its and its subsidiaries' annual revenue nationally from Blue sources. This had the effect of reducing Blues from using non-

Blue subsidiaries and plans, as deriving a too-large percentage of their revenues from non-Blue sources would make them violate the Rules.

63. Moreover, if a Blue is found to not be in compliance with the Rules, the BCBSA could revoke the Blue's membership and rights to use Blue trademarks and products. The Blue would also have to pay the BCBSA a "Re-establishment Fee" of $98.33 per Blue member that the Blue serviced to ostensibly defray the costs of setting up a new Blue administrator in the Blue's erstwhile service areas. For Anthem, the largest of the Blues, this Re-establishment Fee would be almost ***$3 billion***, which exceeds Anthem's annual profits.

64. The Blues are also required to participate in the "Blue Card program." Every member of a Blue plan carries a "Blue Card" that entitles them to access the providers in the Blue networks in every state at the in-network rate. Every Blue is required to process claims by a provider in one service area on behalf of a patient whose Blue plan is based in another service area. The Blues refer to employers located within their licensed territories as "home" members and members who receive services through the Blue network outside of their plans' service as "host" members. In return for processing the claim, the "host" plan receives fees from the "home" plan.

65. The Blue Card program effectively gives each Blue a nationwide network that includes all the members and providers of Blue plans. There are approximately ***107 million*** individuals insured by Blue plans, or approximately one-third of the population of the United States, and more than ***90%*** of physicians and hospitals are in the Blues' provider networks.

66. Furthermore, the Blues coordinate to bid for and service national accounts,[1] with Blue documents stating that for "the national account market, all Blue plans are one." The Blues

[1] "National accounts" are described *infra* in §V.D(1).

have created new products and offerings by pooling their assets to establish a nationwide Blue System to service national accounts and provide national network for providers or subscribers.

67. The BCBSA also explains that that each Blue had a "fiduciary duty" to look out for the "***greater Blue good***" because of the member plans' "codependency." Each Blue CEO sits on the BCBSA board. Thus, BCBSA instructs its members that "***Blue interests come first***." Indeed, in the course of the MDL Action, the Blues have admitted that their CEOs "***must and do act in the best interest of the BCBSA and the Blues System when acting as BCBSA Board Members, even if doing so may conflict with the interest of their individual Plans.***" [Emphasis added].

68. Furthermore, the BCBSA restricts the corporate governance structure of each individual Blue, by requiring each Blue to maintain a classified board. Anthem has repeatedly stated in its public filings that it maintains a classified Board only because the BCBSA requires it to and that as soon as the BCBSA removes this requirement, it will submit to its shareholders a proposal to declassify its Board.

C. Anthem Is Bound to Its Blue Brethren

69. Anthem is by far the largest of the Blues; it is the second largest health insurer in the country, and the only individual Blue among the top five largest health insurance companies in the country. Its exclusive service areas include 14 states; the next largest Blue, HCSC, only has exclusive service areas that include five states. It faces both the same advantages and restrictions as other Blues, by virtue of its membership in the BCBSA, but its size amplifies both. And as such, it is more beholden to the BCBSA than the other Blues.

70. The key benefit Anthem derives from the BCBSA is that the sheer size of the BCBSA gives it bargaining leverage by effectively giving the Compnay access to the entire Blue provider and membership networks through the Blue Card program – all told, approximately

one-third of the U.S. population and well over 90% of all physicians and hospitals. Combined with its substantial non-Blue membership, this gives Anthem tremendous leverage to get lower per-member reimbursement rates from providers because it can feed them a large volume of patients, as well as giving the Company an advantage in seeking business from employers for commercial plans, because Anthem can provide them both steep discounts and a large provider network.

71. But because of its membership in the BCBSA, Anthem also faces restrictions from the Rules, which limit its ability to seek business outside of the 14-state exclusive service areas and its overall growth. To stay in compliance with the Rules, every dollar of non-Blue revenue Anthem earns must be matched by $2.00 of Blue revenue (or $4.00 within its service areas). Otherwise, Anthem risks falling out of compliance, which could lead to its expulsion from the BCBSA and would lose Anthem the access to the valuable Blue brands and networks, as well as force it to pay a fee of approximately $3 billion – an amount greater than its annual profits – to establish its Blue replacement.

72. Moreover, by virtue of its membership in the BCBSA, Anthem has fiduciary duties to the other Blues just as they have fiduciary duties to the Company, which, as described above, requires them to sometimes place the interests of the Blues collectively above the interests of their individual companies. Indeed, beyond the explicit fiduciary duties, Anthem views other Blues as "***comrades in arms***" against non-Blue insurers. [Emphasis added].

73. Swedish has particularly close ties with other Blues, not only serving on the BCBSA's board, but also participating in subcommittees, such as those dealing with BCBSA's national accounts program, strategy, and insights – which include sensitive business information

he would not want competitors to see. He devoted approximately 30 hours per week to BCBSA business.

74. Moreover, Swedish admitted during the trial in the DOJ Action that because Blue CEOs serve together on the BCBSA board and meet to discuss business issues, it would continue to need to support, and the support of, other Blues after the Merger to comply with the Rules.[2]

75. The BCBSA membership and relationship to other Blues is so valuable to Anthem – both because of the positive advantages of provider network and membership access and the $3 billion Re-Establishment Fee Anthem would incur if forced to leave the BCBSA for violating the Rules – that Swedish testified that Anthem would never "consider leaving" the BCBSA "under any circumstances."

D. Anthem and Cigna Compete Fiercely in the National Accounts Market

1. The National Accounts Market and Anthem's Position in It

76. "National accounts" are employer-sponsored health insurance accounts, which are often for ASO, where the insurance claims are funded by the employers but the health insurer provides administrative services and access to provider networks. These accounts involve large numbers of employees, with at least 5,000 members, and they cover employees in multiple states. As such, they are distinct from "large group" insurance – *i.e.*, insurance sponsored by employers with more than 50 or 100 employees to be covered – which are defined by number, but not by complexity or geographical reach.

77. Because national accounts require carriers that can supply in-network providers in all the locations where employees of a company may live, work, and travel, and also may need coverage for retired employees who may want to relocate, employers who are looking to

[2] Generally, unless otherwise qualified by context, references to "the testimony" or "the trial" are references to the testimony offered and trial held in the DOJ Action.

establish a national account are looking for an insurer with a truly national network. As Ken Goulet ("Goulet"), Anthem's then-President of Commercial and Specialty Business, testified, "[Y]ou don't really call yourself a . . . ***national account carrier unless you can cover all 50 states***." [Emphasis added].

78. National accounts have other high-touch client service, technological, and customization needs, and therefore are treated as specific businesses within an insurer rather than lumped in with other large group plans.

79. Large employers increasingly sell their national accounts to fewer insurers because having fewer insurers reduces their administrative costs. But large employers also vet their insurers more carefully. Thus, the purchasing and marketing process – which involves multiple requests for proposals – is lengthier and more resource-intensive.

80. Because of employers' need for high-touch service and geographical reach, only four carriers have the capacity to service national accounts: Anthem, Aetna, United, and Cigna. Sometimes, the Blues, collectively, are also seen as competitors for national accounts in which case they, along with United, Cigna, and Aetna are known as the "BUCA." Humana, often seen as being one of the "big five" health insurers, is not competitive in the national accounts space.

81. Anthem is particularly well-positioned to compete for national accounts because its membership in the BCBSA gives it access to a 50-state nationwide provider network that includes more than 90% of physicians and hospitals.

82. In addition, Anthem has designed its business so that it can provide employers with the high-touch service they demand for their national accounts. Anthem has separate profit and loss centers for national accounts with their own executives, marketing, sales, customer relations, and underwriting teams. Moreover, Anthem benefits from the BCBSA's products,

coordination, and services that it can leverage to provide higher levels of service to its national accounts.

83. National accounts are a major part of Anthem's business, representing around one-third of Anthem's total membership. Anthem services 13 million members across 500 national accounts, many of which include more than 20,000 or 50,000 members with some even representing 100,000 or 200,000 members.

2. Anthem Competes Fiercely with Cigna for National Accounts

84. While United also competes in this space, Anthem views Cigna and Aetna as its main rivals for national accounts, as well as large group accounts. And more recently, Cigna has become a more prominent competitor for Anthem, as Aetna's national accounts business has declined. Cigna also views Anthem as its main rival. If Anthem and Cigna were to merge, in many markets there would then be only one significant player in the national accounts space, or at best two, if Aetna remains in play.

85. In 2013, Anthem implemented a growth strategy specifically targeted at Cigna and Aetna in response to flat revenue growth and a net loss of national account business from 2011 to 2013. Goulet wrote, "I HATE losing to [Cigna] – we shouldn't – I look forward to getting back to winning!" Jerry Kertesz ("Kertesz"), Anthem's then-Vice President of Sales, stated that Anthem needed to be more aggressive and that "***Aetna and Cigna should not exist.***" [Emphasis added].

86. But Anthem was hampered by its reluctance to reduce its ASO fees and because it did not offer trend guarantees – caps on the rate of increase of medical costs – at that time. To compete with Cigna and Aetna, Kertesz authorized the offer of 0% trend guarantees to customers if they would move off of Cigna or Aetna. This entailed some risk to Anthem since it would mean it would have to swallow any increases in cost. Anthem was willing to give trend

guarantees to customers it could pull from Cigna or Aetna, but not for the much larger United, which suggests Anthem viewed the former as more direct competitors. Anthem recognized that this was a "***very aggressive***" tactic. These trend guarantees continued at least up to mid-2016, when the DOJ Action was filed. [Emphasis added].

87. For a time, Kertesz also implemented a bounty program, or "strategic alignment bonuses," where Anthem sales representatives could win bonuses for winning business from Cigna or Aetna.

88. In 2015, Kertesz also instructed his team to "think[] about what we want to do to ***bury Cigna and Aetna***. What is our strategy to ***take them out*** – claim big chunks soon." [Emphasis added].

89. At the DOJ Action trial, the DOJ's redacted statistical evidence also demonstrated that Anthem and Cigna are particularly close competitors, based on the percentage of business they won and lost from each other. The government's expert "concluded that because Anthem and Cigna are winning business from and losing business to each other more than [market] shares predict, his [market concentration] ***calculations and structural analysis actually understate the competitive significance of the merger***[.]" [Emphasis added].

90. Even after the Merger agreement was reached, Anthem's head of sales for national accounts reminded employees "***we are viewing Cigna as a competitor until we are not***," a message that Swedish reiterated in a letter to employees that Cigna remains a competitor until the Merger takes effect. And in 2015 and 2016, Anthem's sales and management workshops identified Cigna as a top competitor and called Cigna's level-funded plan "a new competitive threat." [Emphasis added].

91. As of the time of the DOJ Action trial in November 2016, Anthem and Cigna had continued to compete aggressively for national accounts business. Kertesz testified that Anthem would "***continue to aggressively target Cigna in the national accounts segment***" if the Merger was not consummated. Cigna and Anthem have engaged in a "dogfight" over fees for one customer; and for another customer, Anthem sought to "***eliminate Cigna*** and potentially more (or all) of Aetna from consideration." [Emphasis added].

3. Anthem and Cigna's Competition for National Accounts Drives Innovation for Both and for the Entire Health Insurance Industry

92. Anthem and Cigna, while they view each other as each other's main rivals, have differing business models and competition between them has led to greater innovations and consumer welfare.

93. Anthem's business is based on a traditional "fee-for-service" model – where physicians perform a service and insurance reimburses them for that service. It is able to achieve high revenues because it keeps reimbursements down while generating a high volume of business through signing up many accounts and collecting many fees. However, Anthem's cost management is mainly based on keeping reimbursements low, and its revenue generation is based largely on being able to offer discounts based on those low reimbursement rates. Swedish acknowledged that this business model is becoming outdated, as he testified at trial that the health insurance market is "no longer in a discount world."

94. Cigna is smaller and, therefore, does not have the leverage to force providers to accept the lowest reimbursement rates. So, it is not able to compete as successfully based on the traditional volume- and discount-driven model, and indeed, Cigna has lower discounts than Anthem and its larger rivals. Instead, Cigna has succeeded by innovating, primarily through arranging with providers to give them financial incentives to improve patients' overall health and

perform fewer, but more effective, services, which in industry parlance is referred to as "provider collaborations" or "value-based arrangements." It has also encouraged members to adopt healthier lifestyles and offered them financial incentives, so that they would not need to utilize more cost-intensive medical services as much, which are referred to as "wellness programs." These trends are known as the "volume-to-value" movement and Cigna has been the leader in these innovation areas. These innovations have led some customers to prefer Cigna, despite its lower discounts.

95. Cigna's innovation has led to increases in customer welfare because it has spurred Anthem and other insurers to innovate as well. For example, Cigna has spurred the use of "level funded" accounts, where employers pay a fixed monthly installment every year, but are entitled to refunds to the extent their claim costs fall below a certain level. Anthem, in turn, has been spurred to introduce a similar product because it views "Cigna [as] the strongest competitor in this space" with "the most robust alternative funding options." In particular, Anthem has made this a push in California because Cigna has taken 31 clients from Anthem in the "down-market ASO product sales." In 2015, as Anthem introduced several enhancements to its own level-funded product, Cigna recognized that Anthem "created a product that is a much greater threat." And Cigna's internal plans show that absent the Merger, it would continue to aggressively develop provider collaborations in order to out-compete Anthem.

E. Anthem Courts Cigna Because of Its Fears of Being Left Behind as the Industry Consolidates

96. At the same time as it was competing with Cigna, Anthem recognized that it is in a highly competitive industry. Anthem was also worried about how the industry had been consolidating and did not want to miss the wave. The Officer Defendants recognized in early 2014 that there was "perhaps a single significant transaction remaining" in the field. Around that

time, seeking to be a part of what they viewed as perhaps the last major merger opportunity, Anthem began to negotiate a merger with Cigna.

97. On October 28, 2015, Anthem and Cigna filed a joint proxy statement on Form 424B3 with the SEC (the "Joint Proxy"), illustrating that in mid-June 2014, Anthem and Cigna executives began to regularly meet and discuss the potential Merger. As early as September 2014, the Officer Defendants recognized that the Rules would create, in Zielinski's words, an "***insurmountable barrier to doing the transaction***" with Cigna. Nevertheless, the Officer Defendants continued to negotiate with Cigna throughout 2014 and the first half of 2015. [Emphasis added].

98. On October 1 and 2, 2014, the Anthem Board became involved. This initial Board discussion focused on "the state of the health benefits industry in general, trends in and prospects for the health benefits industry and the health benefits industry transaction environment, as well as Anthem's recent discussions with Cigna."

99. By a month or two later, according to the Joint Proxy, the "senior management" of Cigna and Anthem became focused on how the BCBSA's rules would impact the transaction. At one meeting in November or December 2014, Defendant Schaefer also attended. The BCBSA's rules and how they would affect the transaction continued to occupy both companies' "senior management's" attention in January and February 2015.

100. On February 18 and 19, 2015, the Board again met, where outside counsel "provided an overview to the Anthem board of directors of the basic legal standards and obligations, including fiduciary duties under Indiana law, relevant to the Anthem board of directors' consideration of a potential transaction with Cigna." Anthem's directors and executives continued to discuss "the state of the health benefits industry in general, trends in and

prospects for the health benefits industry and the health benefits industry transaction environment, as well as general transaction structures, governance considerations and financial terms of a possible business combination with Cigna." According to the Joint Proxy, it was also at this meeting that the Board "***discussed and considered the potential impact that a transaction with Cigna would have on Anthem's relationships with other members of the BCBSA and the pending BCBSA antitrust litigation and how the standards and guidelines of the BCBSA would be applied in connection with a merger with Cigna.***" [Emphasis added].

101. The Board concluded at the February 18 and 19, 2015 meeting:

> not to pursue a transaction with Cigna at that time, primarily because there were no signs of imminent industry consolidation that would take away future optionality for Anthem which, when coupled with both the uncertainty in the pending BCBSA antitrust litigation that was still in an early stage and the possibility that an announced transaction could cause a competitor of Anthem to bid for Cigna, led the Anthem board of directors to conclude, on balance, that there was no immediate rush to combine with Cigna at that time and they would instead wait and see how industry developments and the pending BCBSA antitrust litigation would unfolder over the coming months.

102. Shortly after the Board called off Merger talks, in March 2015, Humana and Aetna began to talk about merging. When news leaked out shortly afterwards, this led to a bidding frenzy among Anthem, Aetna, Humana, United, and Cigna where they made multiple bids on one another.

103. Initially, after the Aetna-Humana merger talks began, it appeared that Anthem, through Swedish, also was interested in merging with Humana. The Board did not appear to be involved in these discussions. However, by May 2015, Swedish appeared to refocus on Cigna, at which point the Board again became involved.

104. On May 12 and 13, 2015, the Board met and listened to presentations from Swedish and Zielinski. The Board heard "senior management" regarding:

> key elements of Anthem's ongoing review of the dynamic and changing landscape in the health benefits industry and the various alternatives available to Anthem. Messrs. Swedish and Zielinski also reviewed the history of discussions with Cigna and potential next steps. Following significant discussion and consideration, the Anthem board of directors determined to ***continue to monitor industry developments and potentially attempt to reengage in discussions with Cigna depending on how events continued to unfold***.

[Emphasis added].

Notably absent from the Joint Proxy is any discussion of whether the Board continued to consider the status of the BCBSA's rules or MDL Action, which just three months earlier had been among the deals stoppers for the Board.

105. The Board met again on June 3, 2015. Swedish and other members of "senior management" and outside counsel also attended. The Board "discussed the financial, governance and other key terms of a potential combination with Cigna" and "the state of the health benefits industry in general, trends in and prospects for the health benefits industry, the health benefits industry transaction environment, precedent transactions and the value creation opportunities that might be developed through a combination of the two companies." They "directed Mr. Swedish to send to Mr. Cordani a written proposal setting forth a proposal to combine the companies[,]" but the Joint Proxy is again silent on whether the Board discussed the BCBSA's rules or MDL Action.

106. On June 5, 2015, the Board again met to discuss the Merger negotiations, but the Joint Proxy is silent as to whether the BCBSA's rules or MDL Action was also discussed.

107. On June 9, 2015, the Board again met to discuss the Merger negotiations. They discussed price, equity mix, and governance and "agreed with Cigna's request that Mr. Cordani and Mr. Swedish serve as co-chairman of the integration team," but did not agree on Cigna's proposed premium or requested leadership and governance model. The Joint Proxy is again silent as to whether the BCBSA's rules or MDL Action was discussed.

108. On June 15, 2015, the Board met again to discuss the Merger negotiations. The Board discussed Cigna's requests as they related to the offer, but the Joint Proxy again does not indicate any discussion by the Board regarding the BCBSA's rules or MDL Action.

109. On June 18, 2015, the Board again met to discuss the Merger negotiations. The discussion, led by DeVeydt, focused on "a review of the financial projections, synergy opportunities, financial analysis and financing plans." The Board continued to discuss "the strategic rationale for the transaction . . . ***and the current market rumors about a potential imminent announcement of an acquisition of Company B and Cigna's potential involvement in that process.***" They also discussed "Cigna's potential responses to Anthem's latest proposal to combine the companies and the various ways in which Anthem might proceed in each of those scenarios." Yet, the Joint Proxy again indicates no discussion of the BCBSA's rules or MDL Action. Instead, in its reference to an "imminent announcement of an acquisition . . . and Cigna's potential involvement," the Joint Proxy reveals that the Board was primarily motivated by a desire for Anthem to snatch up a competitor as quickly as possible. [Emphasis added].

110. Later, on June 18, 2015, the Board reconvened to discuss Anthem's receipt of Cigna's written counterproposal. The Board discussed various pricing and governance issues, and "***agreed that time was of the essence.***" However, again the Joint Proxy indicates no discussion of the BCBSA's rules or MDL Action. [Emphasis added].

111. On June 20, 2015, the Board met and heard from Defendant Zielinksi that the BCBSA had been informed of the proposed Merger with Cigna, but the Joint Proxy does not indicate if the Board discussed the Rules, other BCBSA requirements, and their implications for the Merger.

112. Also, on June 20, 2015, Anthem made the Merger offer to Cigna public. Shortly afterwards, Cigna wrote a letter to the Board (which Cigna filed on Form 8-K with the SEC on June 22, 2015) that raised concerns about the equity and role allocation, but also highlighted that Anthem needed to answer "a number of fundamental diligence questions . . . ***including the ability of the combined entity to comply with, and operate successfully under, the BCBSA's rules, [and] the pending BCBSA antitrust litigation***[.]" [Emphasis added].

113. On June 23, 2015, the Board met to discuss what Anthem's counterproposal would be. They learned of the "general market reaction to the public release of Anthem's proposal and the terms of a revised proposal to be communicated to the Cigna board of directors in the hopes that it would guide the parties back to a path that would lead to a transaction." Following the meeting, Anthem communicated a revised proposal "to address Cigna's prior concerns, including more stock consideration, additional board seats, and again offering Mr. Cordani the position of president and chief operating officer in the combined company as well as a seat on its board of directors." Yet, despite how Cigna had told the Board just days earlier about its concerns relating to the BCBSA, the Joint Proxy does not indicate that the Board discussed these concerns or communicated any response to Cigna to address these concerns.

114. The Joint Proxy indicates that during a joint due diligence meeting on June 26, 2015, Anthem's "senior management" discussed with Cigna its BCBSA-related concerns. And on June 30, 2015, Anthem executives and Schaefer also met with Cigna executives to discuss, among other things, "details relating to the BCBSA and the best efforts rule." However, there is no indication that the Board was aware that the management would discuss these concerns or had any input, oversight, or review and that Schaefer informed the rest of the Board. There is only a short paragraph in the Joint Proxy noting that "on July 1, 2015, the Anthem board of directors

held a telephonic meeting and received an update from senior management on the status of discussions between the parties relating to diligence and the terms of the proposed transaction."

115. The Joint Proxy further indicates that Anthem's senior management, including Swedish, had meetings with Cigna over the next few weeks that indicate Cigna reviewed BCBSA's rules and the antitrust litigation, as well as other BCBSA-related documents. However, it does not reveal that the Board had anywhere near a detailed or even cursory discussion of these issues.

116. On July 2, 2015, while Anthem and Cigna were in the middle of their negotiations, Aetna and Humana reached a merger agreement.

117. The Joint Proxy indicates that at the next Board meeting, on July 11, 2015, Zielinksi reviewed with the Board "***the potential inclusion of a regulatory reverse termination fee***[.]" The Joint Proxy does not mention whether the Board even discussed or knew what a "regulatory reverse termination fee" pertained to, whether it was related to the BCBSA's rules and the MDL Action, or whether it was related to other antitrust concerns that may arise. The Board appeared to approve the inclusion of this fee, since the Joint Proxy indicates that subsequent drafts of the Merger Agreement included this provision. [Emphasis added].

118. On July 17, 2015, the Board again met and, "together with senior management, thoroughly discussed and considered the strategic rationale for the transaction and the status of the economic and other material terms of the proposal and authorized senior management to continue discussions with Cigna." Zielinski also reviewed with the Board "the key terms of the proposed merger agreement" and the Board heard about "the various unresolved issues regarding the proposed transaction, which included the inclusion and potential size of the regulatory reverse termination fee, the parties' various positions on dividend harmonization and what the

financial impact would be on the overall transaction by agreeing to various forms of dividend harmonization." However, the Joint Proxy includes no details about what the Board learned about the underlying concerns relating to the regulatory reverse termination fee, the chances of a regulatory termination occuring, and there is no indication any of the BCBSA-related issues, which the Board had prominent notice of from Cigna since June, were addressed or considered.

119. On July 23, 2015, the Board met and approved entering the Merger Agreement with Cigna. However, the Joint Proxy contains no indication that the Board discussed any BCBSA or antitrust concerns at all, even though they had received Cigna's letter raising these concerns a month earlier and agreed to a substantial $1.85 billion reverse regulatory termination fee. Instead, the Board's meeting materials included "a draft definitive merger agreement, an executive summary of the material terms and conditions of the merger agreement, a financial analysis of the consideration proposed to be paid in the merger prepared by each of UBS, Credit Suisse and Anthem senior management and a set of draft board resolutions." Swedish "reviewed the activities and discussions of the previous few weeks, and presented a summary of the proposed transaction, the rationale that supported the proposed transaction, and the financial and strategic benefits that the proposed transaction was expected to create." DeVeydt and other unnamed officers "presented the financial forecast and synergies upon which the merger valuation was predicated and reviewed the synergy opportunities and financing plans related to the proposed transaction." Outside counsel also told the Board about "information regarding the proposed transaction, including a comprehensive overview of the terms of the merger agreement" and "the fiduciary duties of the directors under Indiana law in connection with the proposed transactions." The financial advisors then reviewed their fairness opinions and presentations. The Board then unanimously approved the Merger.

120. Immediately after announcing entry of the Merger agreement, the Board amended Anthem's Bylaws to include a forum selection clause to limit derivative actions, fiduciary duty breach suits, and other corporate litigation to Marion County Superior Court (or the U.S. District Court for the Southern District of Indiana if state court did not have jurisdiction). The timing of the amendment suggested that the Board had concerns it would be sued, and it wanted to cabin where those suits may be tried.

121. While, in general, Anthem stuck to the message that the Merger was motivated by consumer welfare and increased opportunities for innovation, occasionally Defendants would publicly reveal that a major motivational factor was their fear that Anthem would be left behind as other healthcare companies consolidate.

122. For example, in a July 28, 2015 SEC filing on Form 425, which includes a transcript of an Anthem associate town hall in the wake of the Merger announcement, Swedish advised that he did not want:

> [Anthem] to be the American Motors of the healthcare industry. . . . American Motors is gone and now there's the big three in auto, Chrysler, Ford and GM. ***And my vision was that we were going to be of like kind, one of the big three autos*** . . . And so I think we can all feel very good about being the survivor, one of the critical survivors in our sector. . . . So our sense was that in order to survive and really compete in this new world is that we have to grow as a company, we have to leverage our strengths.

[Emphasis added].

123. Moreover, the Joint Proxy states that, among other reasons the Board recommended the Merger, it was also because it "considered the alternatives reasonably available to Anthem if it did not pursue the merger, including continuing to operate on a stand-alone basis or pursuing other strategic acquisitions ***and the fact that Aetna, Inc. had entered into a definitive agreement to acquire Humana, Inc.***" [Emphasis added].

F. The Officer Defendants Spin the Merger for Cigna and Regulators, While Concealing the Obstacles to the Merger

124. As described *infra* in §V.G., the Officer Defendants made many public statements in the wake of announcing their offer to Cigna to reassure Cigna, the public, and the government that: the Merger would increase innovation; Cigna and Aetna had complementary businesses with little overlap, so a merger would lead to little, if any, loss in competition; and the BCBSA's rules would serve no impediment to the Merger; and regulatory approval was likely. In addition to these public statements, Anthem made many other assurances to Cigna and to the government to try to sell the idea of the Merger to them. But in reality, the Officer Defendants were well aware that their rosy picture was a sham because of wide resistance to the Merger by the Blues, and because they intended, all along, for Anthem to swallow, and then sideline, Cigna to eliminate a competitor, in violation of the antitrust laws.

125. Anthem made the same representations to the DOJ in their presentations. At a September 2, 2015 presentation, Anthem and Cigna presented to the DOJ that the Merger would lead to "improved quality and choice" and "facilitate[] cost savings," as well as "accelerate [the] move toward [a] value-based model[.]"

126. Anthem, through Zielinski, claimed to Cigna that it could get the Rules eliminated or modified through the MDL Action. Zielinski also claimed that the Company would get a coalition of Blues to change the Rules or challenge their enforcement. Finally, Anthem claimed the ability to pull "levers" to stay in compliance with the Rules while maintaining Cigna's ability to innovate and grow non-Blue business.

127. But in reality, the Officer Defendants knew that the BCBSA's rules would make it impossible to effect the Merger without violating antitrust laws, and they concealed material

facts from Cigna, so that Cigna would be misled into thinking that the Rules and other BCBSA issues were not, in fact, an inevitable obstacle to a deal that would pass regulatory muster.

128. When Anthem reopened Merger talks after previously having shut them down because of concerns that they would not be able to comply with the Rules, Anthem secretly had its own doubts because Swedish also received information from Anthem executives in this time period – around May 2015 – that indicated the Blues were resistant to changing the BCBSA's rules. However, Swedish concealed this information from Cigna.

129. On the day the Merger was announced, the CEO of the BCBSA sent an email to all Blue CEOs making clear that the BCBSA would review the Merger and its implications toward the Rules. Moreover, even before the Joint Proxy was filed, Cigna and Anthem both received a report that HCSC, the second largest Blue, was reaching out to insurance commissions to challenge the Merger.

130. Swedish was aware of Blue resistance to the Merger, calling them "Nervous Nellies" for their reaction to the announcement. Swedish met in-person with five Blue CEOs, including the CEO of HCSC and Florida Blue. The meetings stressed that the Merger with Cigna would "make Anthem a stronger player long-term, which advantages the Blue System overall." In Blue subcommittee meetings, Swedish had to try to assuage other Blues that Anthem was not using the Merger to compete against Blues with the Cigna brand.

131. But, in information Anthem did not disclose to Cigna, DeVeydt told Swedish in October 2015 about further opposition from the Blues. Furthermore, Zielinski consulted with Swedish when they found out that BCBSA was seeking to change the Rules and other rules to address the Merger. Without informing Cigna, Swedish sought to privately confer with the CEOs of fellow Blues in late 2015.

132. Meanwhile, Anthem continued to mislead the DOJ and Cigna regarding its Merger plans. In response to the DOJ's second request for information in late September 2015, and its Rule 30(b)(6) deposition notice for a designee regarding the Rules in October 2015, Anthem made a presentation to the DOJ in November 2015 stating that both inside and outside of Anthem's 14 Blue territories, "Anthem will continue to offer Cigna branded products," so that members "will have a choice of Cigna or Anthem." Anthem proposed that it could do so and still comply with the Rules through voluntary rebranding of Cigna customers, restructuring, growing Anthem's legacy businesses, and divesting assets, such as low-margin Cigna businesses.

133. However, despite making representations in the Joint Proxy that Anthem "may" be out of compliance with the Rules upon the Merger, Swedish testified at trial that he knew that Anthem would certainly be in violation of the Rules due to Cigna's non-Blue brand revenues and customers outside of Anthem's Blue territory, and thus, his presentations indicating otherwise were misleading. Swedish knew that the only way to be in compliance was to rebrand Cigna customers as Anthem customers – what was called "***Bias to Blue.***"

134. Moreover, to stay in compliance with the Rules, Anthem would have to continue to ensure that every dollar's worth of growth in non-Blue business would be matched by two dollars' worth of growth in Blue business. Given the Blues' division of territory amongst themselves, growth in Blue business would be difficult – this would have the inevitable effect of stifling non-Blue growth. Furthermore, Anthem already had a significant non-Blue business through Amerigroup and other subsidiary brands, which would have further limited non-Blue growth in Cigna business, since Cigna's growth would have to fit in with Anthem's other non-Blue businesses' growth. Despite Anthem's rosy public outlook for Cigna, it internally modeled how it could still profit even if the Rules cut a quarter of Cigna's growth.

135. Anthem also had a history of weakening non-Blue acquisitions while still turning a profit. In 2004, when Anthem merged with WellPoint, it acquired the UniCare brand, which was established to compete against Blue plans outside of Anthem's territory. Anthem was optimistic about UniCare's prospects for expansion because it had innovative products and technology, but UniCare soon became a point of tension between Anthem and the other Blues.

136. Thus, in 2006, Anthem decided to "[f]reeze UniCare expansion" to "[i]ncrease cooperation and WellPoint influence by improving WellPoint's relationship with BCBSA staff and other Blue Plans." In 2008, Anthem executives continued to recognize that UniCare was "[a]ntagonistic to other Blues" and that retaining it would mean a "[c]ontinued adversarial relationship with the Blues" while selling the brand would "[e]liminate[] [a] source of friction with other Blues." Anthem followed through with this plan by announcing, in 2008, that by April 1, 2009, it planned to transition the remaining UniCare customers to Anthem or other Blues when UniCare customers were in their service areas. Anthem admitted that they made this move both because of UniCare's "lack of scale" and "abrasion with other Blues."

137. Though UniCare was "virtually unknown" compared to Cigna, as DeVeydt testified, its presence was enough to cause "abrasion" with other Blues – and DeVeydt believed a similar effect would come from competition with Cigna.

138. Furthermore, the Officer Defendants gave false assurances to the investing public and Cigna that they contemplated giving Cigna executives a substantial role in the Company. For instance, Anthem and Cigna's Joint Proxy state that while Swedish would serve as the CEO of the combined company, Cigna's CEO, Cordani, would serve as President and COO of the combined company.

139. However, the Officer Defendants intended to simply eliminate Cigna as a competitor, including eliminating the competition of Cigna executives. Zielinski and Anthem's lead outside counsel conspired, in emails from June 2015, to "***get rid of Cordani for [Swedish's] benefit***" and Zielinski discussed a "***strategy to take [Cordani] out***." [Emphasis added].

140. Because Anthem's true strategy and motivations were at odds with statements it made to the public, regulators, and Cigna, Anthem made little progress on integration or divestitures, despite Cigna's repeated prodding. In turn, Cigna, sensing that it was being sidelined and disagreeing with Anthem's strategy, also became more reluctant to work together on integration. By the time the DOJ Action commenced in July 2016, Cigna and Anthem had stopped jointly working on integration altogether.

141. Instead, Anthem executives created a secret "Phase 2B" integration plan that specified that it should be conducted "***without Cigna's knowledge***." Instead of the procompetitive pretexts Anthem offered externally, this plan included efforts relating to: "Anthem's continuation to offer Cigna network offering in and out of 14 states"; "Best efforts related work"; and "best-in-bred provider collaboration model." [Emphasis added].

142. At the same time, Anthem began to provide some cover for the eventual unraveling of its scheme by writing white papers to the DOJ touting purported "efficiencies" to be generated by the Merger that would come from applying Anthem's provider discounts.

143. However, behind the scenes, Swedish knew it was becoming even more unlikely that Anthem had a procompetitive path forward because, in another development he did not disclose to anyone outside of Anthem, he knew that, in early 2016, the BCBSA formed a Special Task Force to review changes to the Rules in the context of the Merger, and those changes were not the optimistic procompetitive changes Anthem had earlier touted, but rather were meant to

tighten the Rules and make it harder for a Blue to do non-Blue business and still comply. These proposals included: (a) accelerating the timeline for a Blue plan to re-establish compliance with the Rules instead of giving the plan two years (as Anthem disclosed in the Joint Proxy); (b) levying a higher license Re-establishment Fee (which Anthem had disclosed would be nearly $3 billion); and (c) disallowing national competitors acquired by a Blue plan to rent Blue-branded local provider networks.

144. Furthermore, in 2016, Anthem was unable to obtain the favorable changes it had touted to Cigna and the DOJ. Instead, Anthem came up with a secret plan to allow it to comply with the Rules by leaning into the Blue business, which, as the District and Appeals Courts recognized, was anticompetitive rather than procompetitive. Anthem did none of the things it had told Cigna it would do: it did not organize a coalition of Blues to change the Rules; it did not take a unilateral action to attempt to change the Rules; it did not attempt to break with the Blues in their responses to the MDL Action; and it did not initiate a legal action against the Blues even after the Special Task Force pushed through changes that would make the Rules stricter.

145. Instead, at a June 2016 meeting, Officer Defendants created a "***Bias to Blue***" strategy, which involved the mass rebranding of Cigna customers to Anthem's Blue products in Anthem's 14 states, in offers that they could not refuse because a refusal to rebrand would mean they would not have access to Anthem's networks or discounts. And, indeed, Zielinski sought to give such a reassurance to the BCBSA general counsel. [Emphasis added].

146. Anthem also did not tell Cigna or the public that it was part of a Blue organization, called "Consortium Health Plans" (the "Consortium"), which has the goal of "***making Blue Cross and Blue Shield . . . the carrier of choice for national accounts.***" Anthem is one of 21 Blue plans that are members of the Consortium, where members are required to

adhere to certain pricing practices, devote resources to selling and retaining national accounts, and share best practices with other Consortium plans. Anthem also did not tell Cigna about its fiduciary duties to the other Blues, which would mean the Company must place its own interests below that of the Blues as a whole. [Emphasis added].

147. Anthem's Consortium membership and BCBSA duties would lead to effectively eliminating or reducing Cigna as a competitor against the other Blues because Anthem's BCBSA membership obligates it to help Blues outside its territories in their bids – as other Blues help Anthem win in its territories, whether directly or indirectly through the fact that the total Blue membership represents one-third of all insured. Moreover, Cigna, even if a large part of it were to remain non-Blue, would have less of an incentive to compete against Blues when it is at least partially under the Blue umbrella.

G. The Officer Defendants Make Numerous Misrepresentations, or Omit Information as to Make Disclosures Misleading, to Entice the Public to Support the Merger

148. Anthem, through Swedish and DeVeydt, also made many public statements in support of the Merger after it publicly announced its offer on June 20, 2015, which contained many misrepresentations that overstated the procompetitive rationale for the Merger, understated the BCBSA and regulatory obstacles, and understated the extent of Anthem and Cigna's existing competition and therefore misled the public about the reduction in competition that the Merger would lead to.

149. In an investor presentation, filed with the SEC on June 22, 2015 as an attachment to Form 8-K, entitled "Anthem-Cigna: A Compelling Combination," Swedish, DeVeydt, and Doug Simpson ("Simpson"), Anthem's Vice President of Investors Relations, sold the proposed Merger to the public. The presentation emphasized "Innovative Solutions Driving Affordability & Choice," including how a "National scale drives administrative efficiency" and "Local focus

advances cost of care position" and "Leadership position in advancing provider collaboration and new payment models." It emphasized "Three Pillars to Benefit Combined Entity" of "Provider Collaboration," "Managing Total Cost of Care," and "Consumer Centricity." It also stressed their "[c]onfidence in ability to capture run-rate synergies approaching $2 billion pre-tax within two years post-close."

150. In a press release, also attached to the June 22, 2015 Form 8-K, Anthem further stressed how "the combined enterprise would generate significant annual cost synergies by achieving operating and G&A efficiencies," as well as how it is "***confident in its ability to obtain regulatory approvals. . . . This includes matter related to the [BCBSA].***" In this press release, Swedish stated, "[t]his combination is the absolute best strategy for both organizations to maximize the potential and lead the transformation of the health care industry. Together our companies would rapidly build on each other's complementary strengths to . . . meaningfully deliver innovative, quality solutions to all of our stakeholders." He also expressed "disappoint[ment] in Cigna's insistence on uncommon governance demands [that] has impeded the realization of this combination for shareholders and all stakeholders." But Swedish did not acknowledge that one of the major impediments was not "uncommon governance demands" by Cigna, but rather Anthem's inability or unwillingness to give Cigna enough information to provide it comfort that the Merger would still be able to go forward on procompetitive grounds that would protect the Cigna brand, given Anthem's BCBSA obligations. The press release concluded, "Anthem has engaged with Cigna to explore a potential combination since August 2014 and is making its proposal public today following Cigna's refusal to reasonably negotiate and its insistence on securing governance matters that are not common practice in similar transactions." However, the press release did not disclose that the Board actually called off

Merger talks in February 2015 and that both the Board's earlier concerns and Cigna's current concerns related, in large part, to the BCBSA's rules and MDL Action. The press release also attached Swedish's June 20, 2015 letter to Cigna's board, which again put the onus on Cigna. The letter claimed that Swedish had discussed concerns relating to the BCBSA with the Board – though this discussion is not reflected in the Joint Proxy – and they had: "***resoundingly concluded that any such impacts [relating to the BCBSA] should not act as any impediment to the combination of Anthem and Cigna.***" The letter also claimed, "***based on the analyses of our respective antitrust counsel and information shared to date, we believe there is a consensus of where there is overlap between our companies and that no material substantive antitrust or insurance regulatory issues are present.***" [Emphasis added].

151. Swedish, DeVeydt, and Simpson also hosted a call with investors and researchers on June 22, 2015, and on the same day, a transcript of the call was filed on Form 425 with the SEC. During the call, Swedish also indicated that Zielinski was on the line. The call was attended by analysts from Bank of America Merrill Lynch, Barclays Capital, Wells Fargo Securities, Susquehanna Financial Group, Goldman Sachs, Deutsche Bank, Cowen and Company, Jefferies, Leerink Partners, Wedbush Securities, Sterne Agee CRT, and UBS.

152. Swedish led off the presentation by emphasizing that the Merger would create a company that "would have a strong position across growth markets and the scale to drive greater efficiency and affordability for our customers," and he again emphasized his "confiden[ce] that synergies approaching $2 billion within two years after the closing of the transaction are achievable."

153. During the call, Swedish – unlike in the press releases, letters, and presentations preceding or contemporaneously filed with the call – also addressed "possible concerns related to

the potential impacts a combination could have on Anthem's license agreements with the [BCBSA]." He responded that Anthem's "senior management, legal team and outside advisors . . . spent a lot of time ***ensuring that this issue was fully vetted. We have concluded that any such impacts should not act as an impediment to the combination of Anthem and Cigna.***" He added, "***We're confident in our ability to obtain regulatory approvals including matters related to the [BCBSA].***" Swedish further reiterated the statement in the June 20, 2015 letter to Cigna that "***based on the analysis of our respective antitrust counsel and information shared to date we believe there is a consensus of where there is overlap between our companies and that no substantive antitrust or insurance regulatory issues are present that would prevent completion of the transaction.***" [Emphasis added].

154. Despite Swedish's assurances, analysts pressed about the BCBSA and the Blues. UBS asked Swedish about the effect this Merger might have on his relationship with his "Blues brethren." Swedish responded:

> [O]ur relationship with the Association has never been stronger. . . . ***With respect to the rules and regulations in and around Blue as I noted in my statement we have vetted this very carefully and quite frankly for a considerable length of time even predating the conversations with Cigna. Today we are more convinced than ever that we will navigate our way through some of these issues related to the Blue rules and with respect specifically to best effort requirements***. . . . But specific to the Blue rules we have two years to come into compliance with the rules. So all-in you're looking at something on the order of a three-year process that we would administer which I believe with respect to our relationship with the Blue colleagues we will effectively navigate to a good end with respect to the dialogue that we will have to administer.

[Emphasis added].

155. However, when Goldman Sachs expressed some skepticism about the Blues allowing Cigna to compete as a non-Blue, asking: "Are you saying that the other Blues are okay with seeing . . . sort of a replication of the UniCare strategy that the Company had moved away

from some number of years ago? . . . [H]ow exactly are you going to handle national accounts vis-a-vis the Cigna platform versus Blue Card?[,]" Swedish responded:

> [T]hat's a question that we'll be developing an answer to over time. And the reason I say that is that we have not had any level of conversation with our Blue colleagues. Obviously by virtue of the fact that this was until recently confidential and so we've not broached the subject. Specific to how various parts and pieces of the portfolio might be impacted obviously we're looking forward to the conversation. ***My sense is that it will go well because I think there will be general agreement that this transaction will strengthen the Blue organization, the Blue Association***. And my sense is our colleagues will certainly welcome the opportunity for conversation specific to the kind of questions that you're asking. Let me underscore it's too early to be able to give you a specific response but I do believe the conversations will go well.

[Emphasis added].

156. DeVeydt attempted to bolster Swedish by adding:

> One other item we want to highlight is keep in mind the rules as they're written today we would treat very similar to what we did with Amerigroup which is we would rebrand in our current Blue states that business Blue which would assist us with that. Two is it's important to recognize that the Blue rules are based on a premium equivalent when it comes to ASO. We would obviously fully expect to take advantage of the Blue network. And in these situations in our non-Blue states for national accounts we'd be able to Blue brand it on a premium equivalent basis and use the Blue Card system which then also helps us not only with the Blue rules but drives a great value proposition for the consumer and those customers and a great value proposition for the Blue system. ***So I just think the thing we want to highlight is there are many levers within the Blue rules that are built to continue to enhance the brand and continue to enhance the value proposition for the consumer. And we just plan to use all those rules as they exist today like we did with Amerigroup. So we think there's a very clear path where this would not be material.***

[Emphasis added].

157. Swedish then further added:

> [L]et me just underscore that and maybe present a philosophical perspective. And that is our Blue colleagues are all well aware of the movement in the industry regarding consolidation, regarding all the other strategic moves that are happening. Directional movement is like never before and my sense is that they are totally dialed into the necessity to strengthen Blue.

158. When Goldman Sachs continued to push if BCBSA's rules appeared to be a "sticking point," DeVeydt responded:

> I think the thing I would respond to is the last offer we received from [Cigna] which requested more ownership interest in the long-term aspects of this Company, not less as the form of consideration. I think they see the mutual value that we see. ***We've had ongoing discussions since last August regarding the paths that were afforded to us to comply with the Blue rules*** and I think they recognize the long-term value.

[Emphasis added].

159. Deutsche Bank asked a question about what reaction the non-profit Blues may have to the merger. Swedish, in his response emphasized, "I think the [Blue] organizations are strong ***and I think they will view this as an opportunity to make the Blue, call it the Blue world, even stronger***[.]" [Emphasis added].

160. In a July 24, 2015 investor presentation that promoted the transaction after the Merger was announced, authored by Swedish, Cordani, DeVeydt, and Simpson, Anthem merely recapped its talking points about the "three pillars" of "provider collaboration," "managing total cost of care," and "consumer centricity" and especially highlighted "Affordability Driven By Provider Collaboration and Connected Care."

161. On the same day, Swedish, Cordani, DeVeydt, and Simpson also participated in a conference call with investors, and a transcript of the call was filed on Form 425 with the SEC. The investor participants were analysts from UBS, Stifel Nicolaus, Susquehanna Financial Group, Bank of America Merrill Lynch, Jefferies, Barclays Capital, Goldman Sachs, and Cowen and Company.

162. During the call, Swedish again emphasized "our three strategic pillars of provider collaboration, consumer centricity, and total cost of care management to advance the healthcare experience for our members." He highlighted Cigna's "focus on provider engagement, card

coordination and connected care" would "enhance our ability to engage in innovative solutions and more meaningfully collaborate with providers" because of Cigna's "incredibly strong coordinated care position [and] terribly strong wellness program[.]"

163. DeVeydt added, "Both Anthem and Cigna are confident in the ability to obtain regulatory approval. . . . [W]e believe . . . that ***no substantive regulatory issues are present that would prevent completion of the transaction.***" [Emphasis added].

164. UBS asked about how the transaction would affect the relationships with the Blues. Swedish responded:

> ***[O]bviously we, as you can imagine, have gone through our analytics***. We understand the Blue relationship that is part of our process going forward, one that we believe will not only grow but get stronger over time. We are a Blue organization that will remain Blue. I want to underscore that. ***The combination with Cigna, I think, gives us tremendous opportunities in terms of working off the scale that they bring in non-Blue states. Again, I think our Blue relationships will get stronger.*** And we are now engaged in conversations with the Blue organization so that it better understands the potential coming out of this new relationship. We don't anticipate any issues regarding so-called Blue rules, in large measure because the Blue rules do not dictate go-no go with respect to the closing of this agreement, this acquisition. However, over the course of time, we will be submitting a plan to be fully compliant with what rules there are in the Blue organization related to a combination like this. So net-net we're very excited about the potential. We think the Blue relationship will get stronger. And also in the non-Blue states we believe there's great opportunity for us to strengthen our position by virtue of this combination.

[Emphasis added].

165. Barclays asked if there is a "specific separate regulatory breakup fee" to which DeVeydt responded, "There is a breakup fee in the event we are not able to obtain regulatory approval. ***But we have many levers to pull before we would get to that point. And, again, we have confidence in our ability to close this transaction.***" [Emphasis added].

166. Barclays then asked about whether Anthem planned to compete in the non-Blue states and how other Blues are taking it. Swedish replied:

> First, to be totally transparent, having conversations of any depth with the Blue Association at this stage would have been premature, obviously. However, having said that, ***internally we have gone through lots of analytics regarding, call it, the math of how the Blue rules apply to us and how we may have to adapt relative to those rules at closing***, which is still many months away. Obviously ***we will now engage in conversations with the Association. My expectation is that it will be incredibly collaborative***. Again, underscore, we are a Blue organization and we will abide by those rules. And shortly after closing we will have to administer or deliver a plan that recognizes how we may adjust or adapt to those rules.

[Emphasis added].

167. Goldman Sachs asked if any conversations with regulators had been held and Swedish responded:

> We have not had conversations with regulators of any meaningful nature at this point. Quite frankly, I don't think we've had conversations at all. And now that work does begin. Let me underscore that I think we've got great relationships with our regulators because over the course of time we've had to engage with them quite often actively. . . . We believe we've got the right commitments to developing an affordable healthcare coverage model. We've got a great focus on serving the customer. We've got an incredible network that will exist in all states where we will perform. . . . ***So, the list goes on in and around affordability, choice and quality improvements. And I think that will stand on its own merits and be a significant uplift in terms of [how] regulators view us.*** So, the work begins and we're looking forward to a good outcome.

[Emphasis added].

168. Cordani added that:

> ***the two businesses as they sit today, while large businesses, are quite complementary***[.] . . . [T]he combination is seeking to improve on and expand further on access, affordability and choice of a variety of programs. . . . It's that complementary nature and the ability to deliver more value that we believe is going to enable us to effectively and constructively get to the finish line here.

[Emphasis added].

169. Cowen and Company asked a question about how much of the synergies would be revenue to which DeVeydt responded: "One of the reasons we have such high confidence in the $2 billion in synergies is that we've attributed a de minimis amount toward revenue. . . . I would

say we modeled a de minimis amount of network advantage that we think ***will inure to the consumer because we want to pass that value on***." [Emphasis added].

170. Similarly, on July 24, 2015, Anthem also filed a reassuring letter with the SEC that was sent to providers and broker/employers, emphasizing that the "announcement ***does not alter our current contractual relationships*** and we will continue to operate 'business as usual.'" [Emphasis added].

171. On July 24, 2015, in an article published by the *Wall Street Journal*, Swedish again reassured the public regarding the BCBSA's rules, stating that the Merger would be based on Anthem and Cigna's "***complementary strengths***" and that regarding regulatory and BCBSA requirements, he was "***optimistic [Anthem] will meet the test and be in full compliance with the rules.***" [Emphasis added].

172. On July 24, 2015, Swedish filed an additional letter with the SEC that was sent to other Blues the same day the Merger was announced, in which he stated, in part:

> Our affiliated Blue Cross and Blue Shield Plans are pillars of our communities, and in many cases, have been so for more than 75 years. ***Our commitment to ensuring that consumers have expanded access to affordable health coverage is the foundation of the proposed transaction and will remain Anthem's top priority. With the transaction, our company will be better positioned to apply the insights and access to a broad network and dedicated local presence to address the health care challenges of increasingly diverse segments, membership, and communities we serve.*** As a Blue Cross Blue Shield colleague, you understand that our responsibility as a health benefits company is evolving, and we recognize the need to help purchasers of health care decide how to choose and use health care — not just pay for it. The combined capabilities of these two companies will allow us to follow through on this important responsibility to consumers, and ***create an even stronger organization that is absolutely committed to growing and enhancing the Blue Brands***.

[Emphasis added].

173. However, Swedish also warned in the letter, in tension with his other rosier public statements about the likelihood of Anthem staying in compliance with the Rules, that:

> [A]t the close of the transaction, ***Anthem will not likely be in a position to comply with BCBSA Membership Standard 10 — "Best Efforts" requirement.*** We are in the very early stages of developing an action plan to come into compliance with the requirement. While I have no specifics to offer at this point, we will submit an action plan for approval by the BCBSA Brand Enhancement & Protection Committee within 120 days of closing. ***We are very excited about the opportunities this combination will create, and are committed to continue growing Blue membership.*** I appreciate your ongoing partnership and support.

[Emphasis added].

174. On July 30, 2015, Anthem filed a "FAQ" regarding the Merger with the SEC on Form 425. In the FAQ, the Company focused on "***complementary consumer solutions and a differentiated mix of products and services***," "[c]omplementary platforms," and "the best of the strong local focus and the deep . . . experience we have and a broader suite of available solutions" as the strategic rationale for the deal. The FAQ further noted:

> ***We are confident in our ability to obtain regulatory approval, as our operations are highly complementary and will provide greater choice, increase access to care, and deliver better affordability to current and prospective customers and clients***. . . . Both companies have engaged antitrust counsel and economists to provide an assessment of competitive overlap. The results of those assessments support our confidence in the transaction obtaining DOJ approval.

[Emphasis added].

175. Regarding a question about whether the "current political environment" would lead to arguments "that having only a few large national insurers is actually anti-competitive," Anthem responded:

> [T]he parties believe that we can demonstrate to regulators that ***this transaction increases competition*** and furthers the goals and objectives of achieving a more sustainable health care system, including ***enhanced access, increased affordability and improved quality***[.] . . . [T]he parties believe that the transaction will ***lead to lower – not higher – prices, as the combined company will be able to operate more efficiently and improve affordability and quality***. . . . The combination of Anthem and Cigna will increase competition and choices for consumers ***with our offerings sitting alongside those of numerous other competitors***.

[Emphasis added].

176. In response to a question regarding whether Anthem's membership in the BCBSA will "impact the DOJ analysis," Anthem stated:

> ***We have considered this item, and we do not think this will be an issue.*** Each Blue plan is a separate and active competitor and uses branded and unbranded solutions to win business inside and outside of its licensed territory. ***Anthem and others have competed in this way for many years. Anthem will continue to compete against other Blue plans using the Cigna brand.***

[Emphasis added].

177. In further detail regarding "comfort with the [BCBSA] Rules," Anthem responded:

> There is no requirement for the Blue Cross Blue Shield Association to approve the transaction, and ***we expect to maintain full compliance with our commitments under the Blues brand during and after integration.*** There are certain requirements to participate in the Blues brand ("Blues Rules"), most notably the 'Best Efforts' standard that currently requires 80% of local revenue and 2/3 of national revenue to be sold and serviced under the Blues brand, with a two-year grace period following the completion of a transaction to come into compliance with the Blues Rules. ***We have carefully evaluated the Blues Rules requirements as part of this process and have concluded that there are ample opportunities to deploy the Blues brand for the benefit of customers and clients and remain in compliance with the applicable Blue Rules***. We have identified the practical steps we will take for implementation and will be building these into our detailed integration plan***. Overall, we view the Blues Rules requirements as very manageable***.

[Emphasis added].

178. Anthem also disclosed that it submitted a plan to the BCBSA and that "***[m]ultiple options are available today for our customers and we intend to offer an expanded suite of choices***," and Anthem "will work with our customers and clients to minimize disruption and we expect the overall process to be manageable." [Emphasis added].

179. Swedish also made misleading statements at hearings before the U.S. Senate and U.S. House of Representatives on September 22 and 29, 2015, respectively.

180. During the September 22, 2015 hearing, Swedish emphasized the "three core pillars with respect to how we engage with the marketplace" for Anthem, leading off with "***provider collaboration***," "***building out affordability***," and a "***locally driven pursuit*** in terms of creating true value for customers." He also emphasized "synergies," including information management systems, and "many other opportunities that will drive down premiums." [Emphasis added].

181. Senator Klobuchar pressed Swedish about why he would need "to have these mergers to have these benefits." Swedish replied, in part, that Anthem and Cigna are "***two companies with distinctive portfolios that are complementary***" who are "both serving large [ASO] national accounts environments" where the savings "***go directly to employers.***" [Emphasis added].

182. Sen. Lee asked about how Cigna would be integrated into Blue Cross / Blue Shield plans and if the Rules would limit the combined company's ability to compete under the Cigna brand. Swedish responded:

> We do not compete by way of the license agreement [outside of the 14 states.] . . . [W]e are strictly within those 14 states. So what will happen outside of the 14 states is Cigna will compete[.] . . . Within our 14 states, Cigna may come into the Blue brand but within the national space Cigna will continue to compete[ ]. . . ***With respect to the Best Efforts Rule, we do need to comply, we will have two years to adjust our portfolio and we do not believe it will be an impediment or present a competitive issue.***

[Emphasis added].

183. When Senator Lee again asked if the Rules will cap Cigna's growth, Swedish replied "***we believe it is just the opposite.***" [Emphasis added].

184. Senator Lee also asked why the benefits would be "merger specific" and Swedish replied, "there are three core elements: focus on the consumer, focus on the provider, focus on

building value that is then delivered to the consumer," "53% of our payments to providers is value-based," and the Merger will "accelerate" value-based payments.

185. Senator Hatch asked about the difficulty of entry into the commercial market because of the need to assemble a broad provider network and establish discounts. Swedish responded, "***there is no competitive threat***" because there is "***no overlap***" between Anthem and Cigna, and the "entry points are many" for new competitors. [Emphasis added].

186. Senator Blumenthal asked about barriers to entry and Swedish responded, "Competition is becoming more robust, not less" and Cigna and Anthem are "***complementary . . . without a lot of overlap in the marketplace.***" [Emphasis added].

187. Swedish, in his written testimony to the Senate, also severely misrepresented the competition between Cigna and Anthem, especially in the national accounts space. His written testimony emphasized "three strategic areas, which are the pillars of our proposed acquisition of Cigna: ***1) a better customer experience; 2) cost containment to improve affordability; and 3) strong collaboration with providers***." He repeatedly minimized the extent of the competition between Cigna and Anthem by claiming that "[h]ealth care is flush with competition. . . . Further, when considering the various segments that make up health insurance. . . . [I]t is apparent that ***this transaction will result in minimal shared local markets, both geographically and by product segment.***" [Emphasis added].

188. Furthermore, he stated that "Anthem and Cigna, through complementary product and geographic focuses, will only enhance our ability to serve the needs of large employers. . . . ***One hundred percent of the savings that result from Anthem and Cigna care management programs are passed through to large employers that self-insure.***" This assurance was in marked contrast to his oral testimony, where he demurred when Senator Franken asked if he

could commit to passing "100%" of the savings to customers (evoking frustration from Senator Franken who expressed that the colloquy would have been shorter "if the answer [was] 'yes.'"). [Emphasis added].

189. In his responses to the Senators' written questions, Swedish furthermore repeatedly deflected and minimized the extent of overlap and competition between Anthem and Cigna and again assured them that large employer ASO customers would "directly benefit from the efficiencies we expect to achieve through the transaction, as the cost-of-care savings will be passed directly on to them[.]"

190. In responding to Senator Lee's written question about "product and geographic market overlaps between [Anthem's] business and Cigna's," Swedish responded, "As mapped out in my written testimony, ***the footprint shared by Anthem and Cigna, whether geographically or by market segment, is minimal and highly complementary.***" He further noted, "in the large employer space, companies like Anthem and Cigna primarily provide administrative services[.] . . . ***There is minimal overlap between the two organizations***[.]" [Emphasis added].

191. In response to another written question from Senator Lee regarding whether there is a national market for commercial health insurance or ASO plans, Swedish represented, "Anthem remains steadfast in its belief that health care . . . is inherently local. . . . ***The complementary nature of this proposed transaction will result in minimal overlap, both, geographically, and by product segment***[.]" [Emphasis added].

192. In response to Senator Feinstein's question about consumer's choice of health plans, Swedish responded:

> ***Given the complementary nature of this transaction, both geographically and by market segment, consumers will continue to enjoy a high degree of choice when***

> ***it comes to their health care options.*** In the 14 states where Anthem operates under the Blue Cross or Blue Cross and Blue Shield brand, this transaction will provide better choices to consumers by leveraging Cigna's expertise in product lines that Anthem does not actively market, as well as by integrating the superior capabilities of both companies. In the other 36 states and Washington, D.C. we believe that this combination will encourage greater competition and choice in the marketplace.

[Emphasis added].

193. In answering a question regarding consumer benefits, Swedish represented:

> The benefits to consumers from the combination of Anthem and Cigna have to do with access, affordability, and quality. Specifically, ***by combining the footprints of these two companies, consumers across complementary geographies and market segments will have more options***, enjoying both increased choice and greater flexibility in their health care decision-making.

[Emphasis added].

194. In answering a question about how consumers will benefit when the companies have more than 10% market share in a given market, Swedish represented, "***Across Anthem's and Cigna's different geographical and market segments, if trends hold, consumers can also expect to see more competitors enter the market in the coming years.***" [Emphasis added].

195. Swedish also made several misrepresentations to the House of Representatives during the September 29, 2015 hearing. In his opening oral testimony, he represented that Anthem and Cigna have "***very limited and in most areas no market overlap***" and reiterated that "[t]hose savings [from synergies and better efficiency] then will go to the consumers by way of better premium support." Swedish also reiterated the breadth of competition in the large employer market and the savings that would get passed to them: "We believe it is critically important for the Committee to understand that there are many competitors in [the large employer] space. . . . [T]hese are highly sophisticated buyers of administrative service only arrangements; . . . ***because it is ASO, the savings go back to the employer.***" [Emphasis added].

196. In his written testimony to the House of Representatives, Swedish expressed confidence that Anthem would be able to comply with BCBSA's rules upon consummation of the Merger: "***we are confident that we will continue to remain in compliance with those [Best Effort] rules with more than sufficient flexibility to compete aggressively in the markets in which we will do business under the Cigna brand***." Swedish further represented, "The combination of Anthem and Cigna through complementary product and geographic focuses will only enhance our ability to serve the needs of large employees. . . . One hundred percent of the savings that result from Anthem and Cigna care management programs are passed through to large employers that self-insure." [Emphasis added].

197. In his responses to the House of Representatives' written questions, when asked again about the BCBSA's rules, Swedish responded:

> ***We are confident in our ability to maintain compliance with the rules governing how insurers can operate under the Blue Cross Blue Shield brand.*** Further, we remain steadfast in our belief that ***the complementary nature of Anthem's proposed acquisition of Cigna allows both brands to compete aggressively in the markets in which we would operate***, while continuing to offer consumers greater choice, affordability, and access. . . . . What makes this partnership so attractive to both companies is the opportunity to leverage each organization's distinct strengths across different segments and geographies. It is our shared goal that the combined organization will continue to seek out and take advantage of these opportunities.

[Emphasis added].

198. Swedish again reiterated in response to written questions that Anthem and Cigna have "the distinct and complementary footprints – both geographic and by market segment. . . . . Currently, Anthem competes with other Blue Cross Blue Shield licensees through our Amerigroup, CareMore, Simply Healthcare, and Better Health brands." He again emphasized that "Anthem intends to continue competing with other Blue plans under the Cigna brand. . . . ***[T]here are few shared local markets between Anthem and Cigna.***" [Emphasis added].

199. In response to a written question regarding studies showing high market concentration post-merger, Swedish wrote that the concentration levels are overstated and:

> [the studies] failed to take into account the highly complementary footprints of the two organizations***, in many cases, both companies do not even offer the same product to the same customers in the same geographies.*** Their cursory interpretation of the available market data is not only misleading, but also results in a misrepresentation of the ***minimal shared overlap between Anthem and Cigna.***

[Emphasis added].

200. On November 12, 2015, Anthem filed a response to the American Medical Association's letter concerning the DOJ's opposition to the Merger with the SEC, which again emphasized:

> Together, Anthem and Cigna, which have ***limited overlap in a highly competitive industry***, will be in a better position to improve consumer choice and quality. . . . Anthem's merger with Cigna creates a unique opportunity to benefit consumers by accelerating the move to value-based reimbursement which will provide improved health outcomes for members at lower cost—achieving savings that can be reinvested to benefit current and future members.

[Emphasis added].

201. Swedish's repeated misstatements had a material effect, encouraging all three institutional proxy advisors to recommend voting for the Merger, a fact that Swedish trumpeted. On November 16, 2015, Swedish reported he was "pleased" that Institutional Shareholder Services ("ISS") recommended approval of the Merger and reiterated:

> The Anthem and Cigna businesses are ***highly complementary with very limited overlap in the geographies and market segments in which we operate.*** Together, Anthem and Cigna will be better able to deliver near- and long-term value by increasing access to high quality, affordable healthcare, enhancing collaboration with providers to focus on patient outcomes, accelerating innovation, and from an overall perspective, helping to meet the challenges of the unprecedented transformation in healthcare.

[Emphasis added].

202. On November 23, 2015, Swedish trumpeted the fact that Glass-Lewis & Co., Egan-Jones Proxy Services, and ISS all recommended that shareholders vote for the Merger and again reiterated: "The Anthem and Cigna businesses are ***highly complementary with limited overlap in the geographies and market segments*** in which we operate." [Emphasis added].

203. Even after shareholders approved Anthem's stock issuance, Anthem continued to aggressively market the Merger. For example, on January 15, 2016, Anthem published talking points and Q&A for sales associates that included points, such as:

a. "We will also compete with other Blue plans in our non-Anthem Blue areas to give consumers greater choice and product options."

b. "In states where we don't hold a Blue license, Cigna products **will not** become Anthem Blue Cross Blue Shield products." [Emphasis in original].

c. "This transaction offers the future opportunity to expand our plan offerings to consumers, not narrow them."

d. "Outside of Anthem's 14 Blue states, post-closing the plan is for Cigna to go to market with its current capabilities plus, at some point following the closing, we intend to optimize the best of each company's provider arrangements to improve access, affordability, and quality across all product categories."

e. "This transaction is about improving our ability to collaborate with hospital and doctors to provide the right care in the right place at the lowest cost to improve the health of consumers."

204. And in a detailed Q&A regarding BCBSA issues filed on the same day, Anthem represented:

> Anthem is and will continue to be a Blue Cross Blue Shield licensed company. It is our expectation that the BCBSA and other Blue Plans will recognize the

> positive impact that this combination will have for the marketplace and that they will fully support this combination. . . . ***We expect to maintain full compliance with our commitments under the Blue licensing rules during and after integration***, and we are working closely with the Association and BCBSA Board on this front. These are not new rules and we have experience looking at options with previous transactions.

[Emphasis added].

205. In response to a question regarding whether the transition will mean patients have fewer choices, Anthem responded, "Our combined capabilities and offerings will ***expand consumer access***[.]" [Emphasis added].

206. Regarding a question whether the "acquisition [will] expand [Anthem's] 'Blue' footprint," Anthem responded: "No. Anthem will remain the Blue licensee in 14 states as it was before this transaction."

207. Regarding whether Anthem will compete against Blues in non-Blue territories, Anthem responded: "We compete today with other Blue plans and the new combined company will continue to compete as we do today along with the addition of the Cigna brand. We anticipate that the transaction will permit us to grow our business into new areas and product lines throughout the U.S. and internationally."

208. Regarding whether Cigna products will become "Anthem BCBS products in the states where you don't hold the Blue license," Anthem responded with one word: "No."

209. Regarding the regulatory approval process and timeline, Anthem continued to express that approval was likely by stating that "our transaction continues to move forward on both the federal and state levels. . . . Ultimately, we believe the consumer benefits of this combination will be apparent to all [regulatory] reviewers, and we remain confident we will close the transaction in the second half of 2016."

210. In early 2016, Anthem issued a public statement regarding questions from Congress:

> Together, ***Anthem and Cigna has limited geographical and product segment overlap.*** Anthem operates as the Blue Cross and/or Blue Shield licensee in only 14 states and will continue to market Cigna products in the rest of the country in competition with Blue Cross Blue Shield plans, as it does today. For example, Anthem already competes in our non-Blue service areas as Amerigroup in states like Tennessee and Texas, as CareMore in Arizona and as SimplyHealth in Florida. Cigna products will not become Anthem BCBS products in states where we do not have a Blue license and a significant portion of Cigna revenue is not covered under the specific BCBS requirements.

[Emphasis added].

211. Around the same time, Anthem issued a public statement challenging the California Department of Insurance's opinion against the Merger, emphasizing that "[w]e are confident that the ***highly complementary nature and limited overlap of our organizations*** that will benefit the complex and competitive health insurance markets will be reviewed on the facts by the DOJ." [Emphasis added].

212. Even after the DOJ Action was filed, Swedish continued to market the transaction. In a July 27, 2016 earnings call, Swedish made it a point to discuss the developments relating to the Cigna transaction, including the recent filing of the DOJ's complaint, and claimed the Merger was "specifically designed to tackle our healthcare systems' challenges head on and deliver greater value to consumers by expanding access to high-quality affordable healthcare." Furthermore, Swedish emphasized "we estimate this acquisition will significantly lower costs for our self-funded consumers with over $2 billion in medical cost savings that we've passed directly back to them."

H. The Government Sues to Enjoin the Merger, and Anthem's Procompetitive Pretexts Fall Apart at Trial and Appeal

213. The DOJ sued Anthem and Cigna for violating §7 of the Clayton Act over anticompetitive effects the Merger would have on the commercial market – *i.e.*, the health insurance plans employers provide to employees – and especially the loss of competition and innovation to ASO national accounts. The government's experts calculated the monetary damages from higher health insurance premiums and ASO fees at $383.8 million to $930.3 million.

214. In contrast to Swedish and Anthem's repeated public statements about Anthem and Cigna's lack of overlap, the District Court found that Anthem and Cigna were fierce competitors, and the Merger would eliminate head-to-head competition between Anthem and Cigna. In particular, the District Court cited to Anthem's own documents and testimony indicating that BUCA compete against one another and dominate the market for national accounts. Furthermore, the District Court cited to expert testimony that Cigna and Anthem were particularly fierce competitors, losing and winning business from each other at a rate greater than market shares would predict.

215. Moreover, the District Court found that taking out Cigna, so that the number of national carriers would be reduced from four to three, was significant because this reduces the ability of buyers to play off sellers – a fact that industry participants confirmed during trial. It was common industry practice to rank bidders, tell them where they ranked against each other, and then use those rankings to push down prices; having one fewer bidder meant less leverage for buyers because there would be one fewer bidder to use to push others down.

216. Furthermore, in contrast to the Officer Defendants' public statements about the ease of entry and the amount of competition in health insurance, the District Court found that

owing to the need to have an existing wide infrastructure of provider networks, technology, marketing, sales, and customer service, there existed significant barriers to entry, so that a new competitor would not likely, at least in the immediate next few years, be able to come in and provide competition to replace the lost competition.

217. The District Court noted that "***[n]ational accounts in particular are considered to be the 'innovation incubators' for the entire industry.*** They push carriers to enhance plan design, customer service, technology, and data security, and the innovations they spur are often deployed to other customers and segments." The District Court found it persuasive that because Cigna has not been able to compete as deeply on discounts, "***Cigna has relied upon innovation to compete, directing its focus on ways to improve member health and employer cost outcomes.***" Furthermore, Cigna's innovation "in turn, ***spurred even those carriers with strong provider discounts to improve their products.***" [Emphasis added].

218. Furthermore, the District Court found:

> ***[T]here was evidence that the planned movement of Cigna members to the Blue brand that will be necessary to accomplish the integration in accordance with the rules of the [BCBSA] will also inhibit Cigna's incentive to innovate.*** As executives from both defendants testified, efforts to move members out of Cigna's network, or to require Anthem network providers to apply Anthem rates to Cigna patients, will erode Cigna's relationships with its providers. Because these relationships are fundamental to Cigna's ability to advance its model of collaborative care, Cigna's capacity to innovate in this area will be harmed as well."

[Emphasis added].

219. The District Court also expressed doubt about Anthem's claims that it could achieve "efficiencies" through saving $2.6 billion in general and administrative (or "G&A") and $2 billion in medical costs that it would pass off entirely to the consumer.

220. Furthermore, the District Court noted that no court had actually approved a merger based on efficiencies and reached the same conclusion here because the "***medical cost***

savings are not merger-specific; a significant portion of the medical cost savings and the G&A savings have yet to be verified; and it is questionable whether the medical cost savings can be characterized as an 'efficiency' at all." [Emphasis added].

221. The District Court held that the medical cost savings are not Merger-specific because they are based on the application of rates Anthem had already negotiated with its providers, which is something Anthem did independently of the Merger; Anthem's witness testified that additional savings are not being achieved by Anthem bringing new members to the providers; and therefore, they are not savings that result from the Merger. Rebranding Cigna customers as Anthem/Blue customers would not be Merger-specific because it "***is nothing more than marketing the Anthem product to existing Cigna customers and persuading them to buy it, and Cigna customers can do that now***." [Emphasis added].

222. Since the District Court found that "rebranding" was not Merger-specific, Anthem's claimed efficiencies were doomed because they largely depended on rebranding to stay in compliance with the Rules: in contrast to Anthem's reassurances to Cigna and to the public, rather than rely only somewhat on rebranding, Anthem actually planned to migrate "***the lion's share*** of Cigna customers in our local 14 markets to . . . the Blue brand" and Swedish testified that this meant Anthem "***planned to move as many Cigna members as possible***" to Blue. [Emphasis added].

223. Furthermore, the District Court was skeptical of Anthem's claim that the Merger would allow it to offer services offered by Cigna that Anthem does not, noting that "[t]here has been no testimony that these are patented or proprietary concepts. . . . ***So the merger does not need to take place to enable Anthem to offer the programs that Cigna is selling that customers value – it just needs to develop and offer them.***" [Emphasis added].

224. Moreover, the District Court raised concerns about whether the medical or G&A cost savings are verifiable because there are indications they cannot be achieved. The District Court pointed to internal Anthem documents that "***reflect concerns that providers may not accept the obligation to extend lower Anthem fee schedules to Cigna patients without a fight.***" Moreover, Cigna's CEO, Cordani, testified that Anthem's projected cost savings were unreliable because they depended on an "unproven assumption that providers will not react and renegotiate their fee schedules upward." Alan Muney, Cigna's Chief Medical Officer, went as far as calling Anthem's projections "***nirvana***." Even Anthem's witnesses could not reassure the District Court, with Swedish resisting any notion that Anthem could "drop the hammer" on its providers and, instead, "warned that any reduction in provider costs will take years to come to fruition." And furthermore, the District Court noted that Anthem "may only have limited use for renegotiating provider contracts or invoking the affiliate clause ***because these measures do not help it comply with the Best Efforts Rule***." [Emphasis added].

225. Moreover, to the extent the cost savings depend on integration planning, Anthem's internal documents showed that despite what Swedish acknowledged would have to be a "herculean effort," the integration planning had actually only been stuck at the "high level" planning stages, and moreover, "[t]he record contains compelling evidence of the deterioration of the merging parties' relationship." This was in large part a result of Cigna's belief that Anthem was attempting to reduce Cigna executives' and directors' roles in the combined company; since at least March 2016, the "parties have been at odds . . . over ***Swedish's proposed diminution of Cordani's span of control.***" [Emphasis added].

226. Moreover, the District Court noted that Cordani's testimony "inflicted significant damage on the synergies defense" when Cordani testified that "both ***rebranding Cigna***

customers and imposing lower fee structures would unravel the collaborative relationships with providers that are essential to accountable care and better clinical outcomes." Moreover, Cordani testified that part of Cigna's growth strategy depended on being able to deliver volume to providers – but the "Blue Bias strategy to rebrand Cigna lives . . . ***would reduce the volume Cigna could bring to its providers***." This reduction in volume would "according to Cordani, '***dramatically unwind***' Cigna's collaborative relationships, and rapidly destroy the Cigna value proposition" and, in turn, "diminish[] Cigna's prospects for growth in the non-Anthem states and weaken[] its offerings to its existing customers." Furthermore, this would "***diminish Cigna's ability to innovate***." The District Court also noted that Anthem's witness, Goulet, "predicted that Cigna provider discounts would deteriorate over time for any customers who chose to remain with the Cigna brand due to the migration of volume away from those providers." [Emphasis added].

227. Furthermore, whether these cost savings would be passed to the customer – as Anthem assured the District Court – is called into doubt by "***Anthem's internal documents [that] reflect that the company has been actively considering multiple scenarios for capturing any medical cost savings for itself***, and the corporate executives responsible for that exercise listed 'pass all savings through to customers' as the last of seven potential options" and that it determined that passing all the savings to customer was "***[n]ot the optimal solution to capture [the] most value from [the] deal.***" And another document the District Court cited shows Anthem specifically attempting to "***capture some of the savings by raising its ASO fees.***" Even Anthem's expert calculated savings based on 98% of the savings being passed to the consumer rather than 10%. [Emphasis added].

228. The District Court concluded:

> In sum, the theme of Anthem's defense is that its greater ability to command discounts from providers will save customers money at the end of the day. At the same time, Cigna says that its collaboration with providers will save customers money at the end of the day. Plaintiffs take the position that customers should continue to have a choice between these options, and the Court agrees. . . . ***Eliminating this competition from the marketplace would diminish the opportunity for the firms' ideas to be tested and refined, when this is just the sort of innovation the antitrust rules are supposed to foster. Considering all of these circumstances, and for all of the reasons set forth in greater detail in this opinion, the Court is persuaded that the merger should not take place.***

[Emphasis added].

229. On an expedited appeal, the District Court's decision was upheld. The Appeals Court noted that Cigna was a "reluctant supporter of the merger" and Anthem had "conceded" that "***the loss of Cigna [as] an innovative competitor in a highly concentrated market***" had an "***anticompetitive effect.***" The Appeals Court held that Anthem did not demonstrate any "kind of extraordinary efficiencies" that would be "necessary to offset" the "conceded anticompetitive effect[.]" The Appeals Court further noted that "***[i]t is undisputed that the government met its burden to demonstrate a highly concentrated post-merger market, which would be reduced from four to three competing companies.***" Moreover, "Anthem also does not dispute the definition of the national accounts market, nor that such a market will be even more highly concentrated post-merger." [Emphasis added].

230. Instead, the Appeals Court noted that Anthem's defense of the Merger was premised on efficiencies it asserted the District Court did not take proper account of, but the Appeals Court held that "***Anthem has failed to show that the district court clearly erred in rejecting Anthem's purported medical cost savings as an offsetting efficiency***" because Anthem's "claimed efficiencies" are "***subject to a number of uncertainties.***" The Merger would actually "immediately give rise to upward pricing pressure by ***eliminating a competitor***" and "Anthem could unilaterally raise its prices in response." [Emphasis added].

231. The Appeals Court also cast doubt on Anthem's claims that rebranding Cigna products would create a "new product" that features Cigna's customer service strengths, while also featuring Anthem's lower rates, as "***the record . . . refutes rather than substantiates Anthem's proposed rebranding approach***" because Anthem's own Senior Vice President, Dennis Matheis, testified that rebranding, at least in the short run, would merely mean "offer[ing] Cigna customers Anthem products" in a manner "no different" than Anthem "selling new business in the market." Indeed, the Appeals Court held that "rebranding does not create a merger-specific benefit in either the short- or long-term." [Emphasis added].

232. Furthermore, the Appeals Court observed, "The fact is, it is widely accepted that customers value the existing Cigna product, and that Cigna is a leading innovator in collaborative patient care. ***That threat to innovation is anticompetitive in its own right.***" [Emphasis added].

233. Furthermore, the Appeals Court criticized the savings projections that Anthem offered, observing that while they were "enormous," they "***fall to pieces in a stiff breeze***" and were "***fantastical.***" [Emphasis added].

234. In a concurring opinion, Judge Patricia Millett observed that "***proffered efficiency cannot arise from anticompetitive effects***[.] . . . Rather, the proffered efficiencies . . . must at least neutralize if not outweigh the harm caused by the loss of competition and innovation." Judge Millett noted that the government argued that "***any decrease in provider rates would come through an exercise of unlawful market power. That would be an antitrust violation, not an efficiency.***" [Emphasis added].

235. Furthermore, Judge Millett emphasized that "a number of damaging internal Anthem documents detailed the company's efforts and specific business options for actively

preventing those savings from being passed through to customers and instead capturing the money for itself." Moreover, Judge Millett observed that "none of the large employees who, according to Anthem, stand to gain billions of dollars in savings, have filed any brief in support of this merger."

236. Shortly after the District Court enjoined the Merger, Cigna filed a lawsuit against Anthem for willful breach of the Merger agreement, alleging that Anthem had doomed the Merger to fail regulatory approval by willfully refusing to follow Cigna's proposed procompetitive plan and had, instead, sidelined Cigna, so that Anthem could present an untenable defense based on purported efficiencies. Cigna filed an amended complaint in November 2017, and the parties are currently locked in this dispute. Cigna claims as damages the reverse regulatory termination fee of $1.85 billion and the lost value of the deal, with total estimated damages at $13 billion.

237. On June 2, 2017, the Form S-1 filed with the SEC on October 1, 2015 (which contains the same information as the October 28, 2015 Joint Proxy) was withdrawn upon the Company's request because of the cancellation of the Merger. Thus, the Company will not proceed with the stock issuance.

VI. BOARD INVOLVEMENT/KNOWLEDGE OF UNDERLYING MISCONDUCT

238. The events, as recounted *supra* in §V.E., in the Joint Proxy reveal that the Board either knew the purpose of the Merger was the unlawful purpose to stifle competition or was willfully blind as to the purpose and did not conduct even a minimal investigation as to the risk that the Merger would fail regulatory scrutiny for violating the antitrust laws. Either way, the Board engaged in willful misconduct.

239. The Board had considered the BCBSA's rules and the MDL Action in February 2015, and in part, because of that litigation, chose to terminate Merger discussions with Cigna.

Yet, only five months later, and after considering renewed Merger discussions for two months, the Board approved the Merger. The Joint Proxy indicates almost no discussion of any antitrust or BCBSA issues during this two-month period, which indicates either the Board knew that the Merger was for an unlawful purpose, and wanted to hide their knowing involvement, or that the Board was willfully blind as to the risks and chose not to consider them, despite being warned of these risks directly by the counter-party, Cigna. If the Board took the latter approach, it ignored red flags, which alone is willful misconduct.

240. The content of the Joint Proxy also suggests that the Board was either willfully blind regarding the true rationale or risks of the Merger or was complicit in misleading the public by pushing a procompetitive story that minimized regulatory risks. The Board authorized the dissemination of the Joint Proxy with several misleading procompetitive reasons for the Merger, instead of the actual anticompetitive motive of eliminating a competitor. These misleadingly positive reasons include such "strategic factors" as:

a. "the combined company's ability to provide quality health coverage as affordable as possible and facilitate Anthem's members' access to the highest quality, most effective care possible";

b. "the ability to deliver meaningful value to consumers through expanded provider collaboration, enhanced affordability and cost of care, management capabilities, and innovations that deliver high quality and more affordable health care for consumers";

c. "similar corporate cultures and values";

d. a leadership structure with Swedish as the continued CEO and Chair, Anthem's Board forming nine out of 14 members, and Cordani to become the CEO and COO of Anthem after the Merger is complete;

e. the Board also considered "its knowledge of each of Anthem's and Cigna's business and financial condition" and the "current and prospective business climate in the healthcare industry, including (1) the regulatory environment and the evolution of the Patient Protection and Affordable Care Act; (2) low interest rates and (3) the trend of consolidation and increased competition in all areas of health care, and the likely effect of these factors on Anthem in the absence of the merger;" and

f. "[t]he prospect of significant competition in the future for partners for strategic business transactions."

241. Within the Joint Proxy and Prospectus's Risk Factors section, the Board minimized the risks – although the fact that most of the detailed risk discussions, as they concern the BCBSA's rules and MDL Action, are not mentioned in the background section in describing board meetings may indicate that the Board was willfully blind of these risks and merely signed onto these statements in the Joint Proxy without review.

242. For example, the Joint Proxy contains a discussion of the BCBSA's rules in the Risk Factors section, although it minimizes the risk by stating that "[u]pon completion of the merger, Anthem ***may*** not initially be in compliance with the BCBSA's national 'best efforts' standard." However, the Joint Proxy indicates elsewhere that Anthem "***will***" not be in compliance with the Rules upon consummation of the Merger, a fact that Swedish knew and testified to. [Emphasis added].

243. The Joint Proxy also discloses the Rules' "requirement that at least 66-2/3% of its annual combined national net revenue, as defined by the BCBSA, attributable to health care plans and related services must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield name and marks" and that "[d]ue to the size of Cigna's business, Anthem

may not be in compliance with the National Best Efforts Requirements immediately after completion of the merger." However, this disclosure is misleading, since, in fact, Anthem "***will***" not be in compliance, and also misleadingly minimizes the impact of the Rules by not disclosing that Anthem would also need to achieve 80% of its revenues within its exclusive service areas from Blue sources. [Emphasis added].

244. Furthermore, the disclosure misleadingly minimizes the impact of the Rules by falsely stating that:

> Anthem believes there are multiple options at its disposal to re-establish compliance with the National Best Efforts Requirements[,] . . . including rebranding Cigna health care plans and related services so they are sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks, ceding national Cigna accounts from other Blue Cross and Blue Shield member plans to Anthem or divesting certain business.

245. Moreover, the Joint Proxy minimizes the risk that the Merger could be enjoined by minimizing the extent of the ongoing regulatory investigation. Anthem and Cigna had filed their HSR Act report with the FTC and DOJ on August 27, 2015 and, by September 28, 2015, "received a second request from the DOJ regarding the merger" (although they did not disclose when they received a first request). The disclosure is bare bones and does not discuss what the substance of the request is, nor does the Joint Proxy disclose that the DOJ had asked for a Rule 30(b)(6) corporate designee witness to discuss the implications of the BCBSA's rules, which showed that the DOJ was keenly focused on the BCBSA and that approval of the Merger was at risk because of Anthem's membership in the BCBSA

246. Taken as a whole, the Joint Proxy minimized the risks of failure to obtain regulatory approval by minimizing the risks or burying the risks in short disclosures, as well as misdirecting the public as to the rationales for the Merger while overstating its benefits. As a result, these disclosures were misleading and improperly induced Anthem shareholders to

approve the stock issuance and Cigna shareholders to approve the Merger. The Board committed willful misconduct by knowingly allowing a misleading Joint Proxy to be disseminated, or by being willfully blind as to the risks of the Merger and thus not exercising their duty of oversight over the Company and its officers, and allowing the Company and its officers to disseminate a misleading Joint Proxy.

247. As is apparent from the Joint Proxy, and filings in the DOJ Action, the Board's main motivating factor for rushing toward a merger was to prevent Anthem from being left on the sidelines. It chose to wait in February 2015 because of the "early" stage of the MDL Action and because "there were no signs of imminent industry consolidation." Yet only five months later, when the MDL Action would not have moved forward so much as to change their views (moreover, the advancing litigation would have only given them less cause for optimism that the BCBSA's rules would align with the Merger), the Board members changed their minds because they did not want Anthem to be "left out of the remaining consolidation."

248. The Board knew about the Rules, which was the subject of discussion at the February 2015 meetings. Thus, the Board knew that Anthem needed to achieve 80% of its revenue within its BCBSA exclusive service areas from Blue plans and 66.66% of its nationwide revenues from Blue plans.

249. The Board also knew, or committed willful misconduct by not doing any investigation to determine, based on Cigna's size, that it would be impossible for Anthem to meet the requirements of the Rules once Anthem merged with Cigna, whose plans were not Blue plans, unless it shifted a massive number of Cigna subscribers to Blue plans – a process the Board and Anthem called "rebranding."

250. Moreover, the Board knew that Anthem already had a significant portion of its business from non-Blue sources, which consists of approximately one-quarter of its membership, and marketed through its subsidiaries Americare, UniCare, SimplyHealth, and CareMore. Thus, the Board knew, or was willfully blind to the fact, that Anthem was already at a saturation point when it came to complying with the Rules and that violating it upon the Merger would be a certainty – not merely a possibility.

VII. DAMAGES TO THE COMPANY

251. As a result of the Individual Defendants' willful misconduct, Anthem engaged in an unlawful and deceptive scheme to seek approval of the Merger for procompetitive reasons, when the real reason was to stifle competition. Anthem's conduct violated §7 of the Clayton Act by seeking to swallow a competitor and reduce competition, harm consumers, and increase its own profits through unlawful exercises of monopoly and monopsony power, to its own detriment and the detriment of its shareholders. Federal and state government agencies then moved to successfully enjoin the Merger, which has led to Anthem incurring tens of millions of dollars in deal-related and litigation costs and the opportunity cost of billions of dollars by losing the opportunity to grow into a value-enhancing new company.

252. Further, as a direct and proximate result of the Individual Defendants' actions, Anthem has expended, and will continue to expend, significant sums of money in relation to the deal, antitrust litigation, and the defense against Cigna's lawsuit that alleges Anthem willfully breached the Merger agreement and, therefore, sank its chances for regulatory approval. Such expenditures include, but are not limited to:

a. millions of dollars spent on financial advisors, due diligence, and legal counsel in connection with the Merger;

b. millions of dollars spent defending the Merger against the government; and

c. $13 billion, the amount Cigna is claiming in damages in its breach of contract suit, including the $1.85 billion reverse regulatory termination fee, as well as the value of the Merger, if Anthem is found to be liable to Cigna for breach of the Merger Agreement.

253. Finally, Anthem's business, goodwill, and reputation have been, and will continue to be, severely damaged by the Individual Defendants' willful misconduct by allowing and/or failing to prevent the Company's willful pursuit of the Merger for anticompetitive reasons in violation of the antitrust laws.

VIII. DERIVATIVE ALLEGATIONS

254. Plaintiff brings this action derivatively in the right, and for the benefit, of Anthem to redress the breaches of fiduciary duty and other violations of law committed by the Individual Defendants, as alleged herein.

255. Plaintiff will adequately and fairly represent the interests of Anthem and its shareholders in enforcing and prosecuting the Company's rights, and Plaintiff has retained counsel experienced in prosecuting this type of derivative action. Plaintiff has continuously held Anthem stock throughout the Relevant Period and will continue to hold Anthem stock through the resolution of this action.

256. Plaintiff has not made a pre-suit demand on the Board to assert the claims set forth herein against the Individual Defendants because such a demand would have been futile, and is thereby excused, since the allegations herein, at minimum, permit the inference that the directors lack the requisite disinterest to determine fairly whether these claims should be pursued.

IX. DEMAND FUTILITY ALLEGATIONS

257. A demand on the Board to bring the claims asserted herein would be a futile and useless act because there is a reasonable doubt that a majority of the current 10-member Board is capable of making an independent and disinterested decision about whether to institute and vigorously prosecute this action.

258. Defendants Clark, Dixon, Hay, Hill, Peru, Schaefer, and Tallett, who constitute a supermajority of the Board as seven out of the 10 directors, cannot exercise their independent and disinterested judgment to institute and prosecute this action because they have a strong interest in refusing to bring claims asserted by Plaintiff to protect themselves against a substantial likelihood of liability. They have committed willful misconduct by willfully causing Anthem to attempt to acquire Cigna for the unlawful purpose of eliminating competition in violation of the Sherman and Clayton Acts, as well as willfully making misrepresentations in the Joint Proxy, or allowing them to be made without any good-faith review as to their accuracy, so as to mislead Anthem shareholders into approving the stock issuance needed to provide capital for the Merger.

259. Evidence of the Director Defendants' willful misconduct in willfully pushing for Anthem to attempt to acquire Cigna in violation of the antitrust laws includes the following:

a. The Director Defendants had determined not to go forward with Merger negotiations with Cigna in February 2015, in part, because of concerns relating to the BCBSA's rules and antitrust concerns. Yet, only three months later, they determined that Anthem could renew negotiations with Cigna, and just two months after that, agreed to approve the Merger. Yet, the BCBSA's rules and MDL Action did not reach a more favorable posture during that period. The only material factual change was the imminent consolidation of the health insurance industry, with Aetna and Humana negotiating, and

then agreeing, to a merger by July 2, 2015. The Director Defendants themselves admit this was a key motivation, as the Joint Proxy states that one of the reasons for recommending the Merger was "***the fact that Aetna, Inc. had entered into a definitive agreement to acquire Humana, Inc.***" [Emphasis added].

b. Moreover, the Joint Proxy includes no statements that the Director Defendants considered the BCBSA-related issues in their May through July 2015 deliberations, despite the fact that these very issues were among their stated reasons for breaking off negotiations just months earlier and that Cigna had specifically flagged these issues for the Board in June 2015.

c. The rush to complete the Merger, coupled with the silence in the Joint Proxy regarding the BCBSA-related issues, provides strong evidence that either the Board knew that the reason for rushing toward a Merger was to eliminate a competitor and gain scale, and thus push the Company to engage in an unlawful action by violating the antitrust laws, or was willfully blind to the antitrust concerns and consciously chose to ignore those concerns. Either way, the Board committed willful misconduct in pushing for an unlawful merger.

260. Evidence of the Director Defendants' willful misconduct in willfully making misrepresentations in the Joint Proxy, or in being willfully blind regarding the Joint Proxy's accuracy, which led to the Director Defendants breaching their fiduciary duties toward Anthem shareholders by misleading them, includes the following:

a. The Director Defendants authorized statements painting the misleadingly positive "strategic factors" for the Merger, which included increasing affordability, provider collaborations, and a substantial role for Cigna in the management of the joint

company, despite the evidence that the real reason for the Merger was to eliminate Cigna as a competitor;

b. The Director Defendants authorized incomplete disclosures that omitted material facts, and thus misleadingly minimized the risks that those statements purportedly disclosed, such as the following:

i. that the Merger "***may***" cause Anthem to fall out of compliance with the Rules, when in fact Anthem would certainly fall out of compliance as soon as the Merger closed [emphasis added];

ii. that there are "***multiple options***" for Anthem to re-establish compliance when, in fact, Anthem would need to rely primarily on converting Cigna accounts to Blue accounts [emphasis added];

iii. that Anthem had received a "second request from the DOJ regarding the merger [for antitrust review]" without disclosing the substance of the request and that the DOJ had asked for a Rule 30(b)(6) corporate designee witness to discuss the implications of the BCBSA's rules; and

iv. that the Rules require Anthem to derive "66-2/3% of its annual combined national net revenue" from Blue sources, without disclosing that the Rules also require Anthem to derive 80% of those revenues from Blue sources in its exclusive service areas, and thus not disclosing to shareholders the severity of non-Blue growth limits the Rules require; and

c. The Director Defendants authorized risk disclosures in such a way as to minimize them, thus misleading shareholders as to significance, by listing them in generic boilerplate terms or burying disclosures in the midst of a several-hundred-page

document where other statements that painted a positive picture were more prominently displayed.

261. As described in detail above, Defendants Clark, Dixon, Hay, Hill, Peru, Schaefer, and Tallet's willful misconduct exposes them to personal liability, and therefore, disqualifies them from considering a demand.

262. In addition, as an independent and alternative ground, demand would be futile as to Defendants Schaefer, Tallett, Clark, Hill, and Peru, and Non-Party directors Boudreaux and Jallal, because disabling conflicts of interest would prevent them from exercising their independent and disinterested judgment as to Plaintiff's claims.

263. Demand would be futile as made to Defendant Schaefer because his long ties to the Company prevent him from exercising his independent and disinterested judgment in assessing a litigation claim against the Company's directors and officers. He has served as a director of the Company for 17 years (since 2001) and also as a director of the Company's predecessor, Anthem Insurance Companies, Inc., for an additional six years (since 1995), for a total combined tenure of 23 years. Further, Defendant Schaefer, as described in the paragraphs above, faces a substantial risk of incurring personal liability for his willful misconduct in causing the Company to violate antitrust laws by pushing for the anticompetitive Merger and in causing the Company to violate securities laws by filing a misleading Joint Proxy.

264. Demand would be futile as made to Defendant Tallett because of her 45-plus-year career in healthcare, which would prevent her from exercising independent and disinterested judgment in assessing a litigation claim against directors and officers of one of its largest players. Defendant Tallett was Director of Worldwide Strategic Planning at Warner-Lambert, a pharmaceuticals company, from 1973 to 1987. Then, from 1987 to 1996, she was Director of

Marketing Operations and then President of Centocor Pharmaceuticals. From 1996 to 2003, she served in various chief executive roles at Dioscor, Inc., Ellard Pharmaceuticals, Inc., Galenor, Inc., and Marshall Pharmaceuticals, Inc., which were all pharmaceuticals companies. Furthermore, she founded and has served as Principal of Hunter Partners, LLC, a healthcare consulting company, since 2002. In addition, Defendant Tallett, as described in the paragraphs above, faces a substantial risk of incurring personal liability for her willful misconduct in causing the Company to violate antitrust laws by pushing for the anticompetitive Merger.

265. Demand would be futile as made to Defendant Clark because of his extensive involvement in healthcare, which would prevent him from exercising independent and disinterested judgment in assessing a litigation claim against directors and officers of one of its largest players. Between 2006 to 2009, he was CEO (and since 2007, Chairman) of Cardinal Health, Inc., a healthcare products and services company. In addition, Defendant Clark, as described in the paragraphs above, faces a substantial risk of incurring personal liability for his willful misconduct in causing the Company to violate antitrust laws by pushing for an anticompetitive merger.

266. Demand would be futile as made to Defendant Hill because her long ties to the Company prevent her from exercising her independent and disinterested judgment in assessing a litigation claim against the Company's directors and officers. Hill has been a director of the Company since 2004, for a 14-year tenure, and was a director of the Company's predecessor, Wellpoint Health Networks Inc., for another 10 years, from 1994 to 2004, for a combined tenure of 24 years. In addition, Defendant Hill, as described in the paragraphs above, faces a substantial risk of incurring personal liability for her willful misconduct in causing the Company to violate antitrust laws by pushing for the anticompetitive Merger.

267. Demand would be futile as made to Defendant Peru because his long ties to the Company prevent him from exercising his independent and disinterested judgment in assessing a litigation claim against the Company's directors and officers. Peru has been a director at the Company since 2004, for a 14-year tenure, and was director of predecessor Wellpoint Health Networks Inc. since 2003, for a combined tenure of 15 years. In addition, Defendant Peru, as described in the paragraphs above, faces a substantial risk of incurring personal liability for his willful misconduct in causing the Company to violate antitrust laws by pushing for the anticompetitive Merger.

268. Demand would be futile as made to Non-Party director Boudreaux because she is an employee of the firm under the supervision of the Board. She cannot be expected to independently and disinterestedly evaluate claims against the very persons who are responsible for her daily livelihood. Moreover, she cannot be expected to independently and disinterestedly evaluate claims that involve the Blues and the BCBSA because she has long been involved with them. She was President of Blue Cross Blue Shield of Illinois from 2002 to 2005, and Executive Vice President at the second largest Blue, HCSC, from 2005 to 2008, and in a case where the anti-competitive effects of the BCBSA's rules play a significant role, she cannot be expected to hold a disinterested view. Furthermore, she is a director of the BCBSA, which further prevents her from exercising her independent and disinterested judgment, because the BCBSA is still embroiled in the MDL Action and she might, therefore, have a risk of personal liability in connection with that litigation. Furthermore, she spent 20 years of her career at Aetna, leaving in 2002 as a Senior Vice President, and immediately before joining Anthem, was Executive Vice President at United. Having spent so much of her career in the small world of the largest

insurers, she cannot be expected to exercise independent and disinterested judgment in a claim involving one of its largest players.

269. Demand would be futile as made to Non-Party director Jallal because her 25-plus-year career in the biopharmaceutical field would prevent her from exercising independent and disinterested judgment in assessing a litigation claim against directors and officers of one of the largest healthcare insurers, since as someone in the pharmaceuticals industry, she likely depends on health insurers for a large portion of her companies' income. Most recently, she has served as Executive Vice President of AstraZeneca PLC, a pharmaceuticals company, and as President of its subsidiary, Medimmune Inc., since 2013, along with other executive roles at Medimmune Inc. since 2006.

X. CLAIMS FOR RELIEF

COUNT I
Breach of Fiduciary Duty
(Against All Individual Defendants)

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

271. The Individual Defendants each owe (and owed) Anthem and its shareholders fiduciary duties of loyalty, good faith, candor, trust, and due care in managing the Company's affairs.

272. As detailed above, the Individual Defendants breached their fiduciary duties by permitting Anthem, its directors, and officers to violate the antitrust laws, through attempting to complete a merger for the purpose of eliminating a competitor, and to mislead the public regarding the rationale for the Merger by allowing the Company to issue a misleading proxy statement to entice shareholders to approve a stock issuance, as well as the Company's own internal governance regulations.

273. As a direct and proximate result of the Individual Defendants' breaches of their fiduciary duties, Anthem has been damaged, not only monetarily, but also with regard to its corporate image and goodwill, having deceived the market into believing a proposed merger would have procompetitive effects when, in reality, it was doomed to fail regulatory scrutiny.

274. Plaintiff, on behalf of Anthem, has no adequate remedy at law.

COUNT II
Corporate Waste
(Against the Individual Defendants)

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

276. By causing Anthem to enter a merger agreement for the purpose of violating the antitrust laws, and thus subjecting Anthem to the costs of defending lawsuits, the possible payment of a reverse regulatory termination fee, and the costs of entering a merger agreement and soliciting shareholder approval that were doomed to fail, the Individual Defendants have caused Anthem to waste valuable corporate assets.

277. As a direct and proximate result of the Individual Defendants' corporate waste, Anthem has suffered damages, not only monetarily, but also to its corporate image and goodwill.

COUNT III
Unjust Enrichment
(Against the Individual Defendants)

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

279. As a result of the misconduct described herein, the Individual Defendants will be, and have been, unjustly enriched at the expense of the Company and its shareholders.

280. The Individual Defendants granted, authorized, approved, and/or received tens of millions of dollars in outsized executive compensation or director fees while condoning,

directing, or committing the misconduct alleged herein. The Individual Defendants should be required to disgorge the ill-gotten gains they have obtained, and/or will otherwise unjustly obtain, at the expense of Anthem and its shareholders. A constructive trust for the benefit of the Company should be imposed thereon.

281. All incentive compensation payments and stock sale proceeds granted, authorized, approved, and/or received by the Individual Defendants were at the expense of Anthem. The Company was inadequately compensated for these payments and stock sale proceeds.

282. As a direct and proximate result of the Individual Defendants' unjust enrichment, Anthem has suffered damages, not only monetarily, but also to its corporate image and goodwill.

XI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment as follows:

A. Declaring that Plaintiff may maintain this derivative action on behalf of Anthem and that Plaintiff is a proper and adequate representative of the Company;

B. Declaring that the Individual Defendants have breached their fiduciary duties of loyalty to Anthem;

C. Determining and awarding to Anthem the damages sustained by it, as a result of the breaches of fiduciary duty and other claims set forth above from each of the Individual Defendants, jointly and severally;

D. Awarding to Anthem restitution from the Individual Defendants and ordering disgorgement of all profits, benefits, and other compensation obtained by them, including all profits, special benefits, and unjust enrichment they have obtained as a result of their unlawful conduct, payment of incentive compensation (whether in the form of cash bonuses, stock awards, or stock option grants), and common stock sale proceeds;

E. Directing Anthem to take all necessary actions to reform and improve its corporate governance and internal procedures, enable the Company to comply with the Company's existing governance obligations and all applicable laws, and protect the Company and its stockholders from a recurrence of the damaging events described herein, including, but not limited to, the following specific relief:

(i) establishing more robust internal procedures to vet mergers for their competitive rationale;

(ii) establishing more robust training for directors to understand the BCBSA's rules that Anthem is subject to, and their implications for Anthem's business; and

(iii) requiring the Company to implement additional audit, compliance, and internal control procedures;

F. Awarding to Plaintiff the costs and disbursements of the action, including reasonable attorneys' fees, accountants' and experts' fees, costs, and expenses;

G. Awarding pre- and post-judgment interest; and

H. Granting such other and further relief as the Court deems just and equitable.

XII. JURY DEMAND

Plaintiff demands a trial by jury.

DATED: October 30, 2018

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Attorneys for Plaintiff Henry Bittmann

VERIFICATION

I, Henry Bittmann, hereby verify that I have authorized the filing of the attached Verified Stockholder Derivative Complaint. I have reviewed the Verified Stockholder Derivative Complaint, and the facts therein are true and correct to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

Dated: 10/26/18

HENRY BITTMANN