

CR 20-00425-EJD

# United States District Court

FOR THE  
NORTHERN DISTRICT OF CALIFORNIA

VENUE: SAN JOSE

SEALED BY ORDER OF THE COURT

**FILED**

May 18 2021

SUSAN Y. SOONG  
CLERK, U.S. DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO

UNITED STATES OF AMERICA,

V.

MARK SCHENA,

DEFENDANT(S).

## SUPERSEDING INDICTMENT

18 U.S.C. §§ 1349 - Conspiracy to Commit Health Care Fraud  
18 U.S.C. § 1347 – Health Care Fraud  
18 U.S.C. § 371 – Conspiracy to Pay Illegal Kickbacks  
18 U.S.C. § 220 – Payment of Illegal Kickbacks  
15 U.S.C. §§ 78j & 78ff;  
17 C.F.R. 240.10b-5 – Securities Fraud;  
18 U.S.C. §§ 981(a)(1)(C) & 982(a) & 28 U.S.C.  
§ 2461 – Criminal Forfeiture

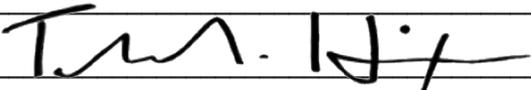
+

\_\_\_\_\_  
A true bill.

\_\_\_\_\_  
/s/ Foreperson of the Grand Jury

\_\_\_\_\_  
Foreman

\_\_\_\_\_  
Filed in open court this 18th day of  
May, 2021

\_\_\_\_\_  
 Clerk

\_\_\_\_\_  
Bail, \$ No Process

\_\_\_\_\_  
Hon. Thomas S. Hixson, U.S. Magistrate Judge

**FILED**

May 18 2021

SUSAN Y. SOONG  
CLERK, U.S. DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO

**SEALED BY ORDER OF THE COURT**

1 STEPHANIE HINDS (CABN 154284)  
Acting United States Attorney

2 HALLIE HOFFMAN (CABN 210020)  
Chief, Criminal Division

3 WILLIAM FRENTZEN (LABN 24421)  
Assistant United States Attorney

4 DANIEL KAHN (NYBN 4196413)  
Acting Chief  
U.S. Department of Justice, Fraud Section

5 JACOB FOSTER (CABN 250785)  
JUSTIN WEITZ (NYBN 5027966)  
Assistant Chiefs  
U.S. Department of Justice, Fraud Section  
950 Pennsylvania Avenue NW  
Washington, DC 20005

11  
12  
13 UNITED STATES DISTRICT COURT  
14 NORTHERN DISTRICT OF CALIFORNIA  
15 SAN JOSE DIVISION

16 UNITED STATES OF AMERICA,

17 Plaintiff,

18 v.

19 MARK SCHENA,

20 Defendant.

) Case No. CR 20-00425-EJD

) VIOLATIONS: 18 U.S.C. § 1349 –  
) Conspiracy to Commit Health Care Fraud and  
) Wire Fraud; 18 U.S.C. § 1347 – Health Care  
) Fraud; 18 U.S.C. § 371 – Conspiracy to Pay  
) Illegal Kickbacks; 18 U.S.C. § 220 – Payment  
) of Illegal Kickbacks; 15 U.S.C. §§ 78j & 78ff;  
) 17 C.F.R. 240.10b-5 – Securities Fraud; 18  
) U.S.C. §§ 981(a)(1)(C) & 982(a) & 28 U.S.C.  
) § 2461 – Criminal Forfeiture

21 )  
22 )  
23 )  
24 )  
25 )  
26 )  
27 )  
28 )  
SAN JOSE VENUE

FILED UNDER SEAL

23 SUPERSEDING INDICTMENT

24 The Grand Jury charges:

25 Introductory Allegations



1 the Centers for Medicare and Medicaid Services (“CMS”), a federal agency under the United States  
2 Department of Health and Human Services (“HHS”).

3 8. The Medicaid program (“Medicaid”) was jointly funded by the federal and state  
4 governments and was a program that provided health care benefits to certain low-income individuals and  
5 families in states. Medicaid was administered by CMS and various state agencies.

6 9. The United States Department of Defense, through the Defense Health Agency,  
7 administered the TRICARE program (“TRICARE”), which was a comprehensive health care insurance  
8 program that provided health care benefits to United States military personnel, retirees, and their families.

9 10. Medicare, Medicaid, and TRICARE were each a “Federal health care program” as defined  
10 in Title 42, United States Code, Section 1320a-7b(f), and a “health care benefit program” as defined in  
11 Title 18, United States Code, Section 24(b).

12 11. Individuals who received benefits under Medicare, Medicaid, and TRICARE were referred  
13 to as “beneficiaries.”

14 12. Diagnostic testing laboratories, physicians, clinics, and other health care providers, all of  
15 which provided services to beneficiaries, were able to apply for and obtain a “provider number.” A health  
16 care provider that received a provider number was able to file claims with Medicare, Medicaid, and  
17 TRICARE to obtain reimbursement for services provided to beneficiaries.

18 13. To participate in Medicare, Medicaid, and TRICARE, providers were required to submit  
19 an application in which the providers agreed to abide by the policies and procedures, rules, and regulations  
20 governing reimbursement. To receive funds, enrolled providers, together with their authorized agents,  
21 employees, and contractors, were required to abide by all provisions of the Social Security Act, the  
22 regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued  
23 by CMS, relevant state and federal agencies, and authorized agents and contractors. Health care providers  
24 were given and provided with access to manuals and services bulletins that described proper billing  
25 procedures and billing rules and regulations.

26 14. A health care provider who was assigned a PIN and provided services to beneficiaries was  
27 able to submit claims for reimbursement that included the PIN assigned to that medical provider.  
28 Payments were often made directly to a provider of the goods or services, rather than to a beneficiary.

1 This payment occurred when the provider submitted the claim for payment, either directly or through a  
2 billing company.

3 15. Medicare, Medicaid, and TRICARE regulations required health care providers to maintain  
4 complete and accurate patient medical records reflecting the medical assessment and diagnoses of their  
5 patients, as well as records that documented actual treatment of the patients to whom services were  
6 provided and for whom claims for payment were submitted by the physician. Medicare, Medicaid, and  
7 TRICARE required complete and accurate patient medical records so that Medicare, Medicaid, and  
8 TRICARE would be able to verify that the services were provided as described on the claim form. These  
9 records were required to be sufficient to permit Medicare, Medicaid, or TRICARE, or their contractors,  
10 to review the appropriateness of payments made to the health care provider.

11 16. Medicare, Medicaid, and TRICARE paid for claims only if the items or services were  
12 medically reasonable, medically necessary for the treatment or diagnosis of the patient's illness or injury,  
13 documented, and actually provided as represented to Medicare, Medicaid, and TRICARE. Medicare,  
14 Medicaid, and TRICARE would not pay for items or services that were procured through kickbacks and  
15 bribes.

16 Commercial Insurance Plans

17 17. Commercial insurance plans were provided by private health insurance companies  
18 ("Commercial Insurers") that offered individual and group health benefit plans under which individuals  
19 could obtain coverage for health care items and services. Individuals who received benefits from  
20 Commercial Insurers were referred to as "members."

21 18. Each of the Commercial Insurers was a "health care benefit program" as defined in Title  
22 18, United States Code, Section 24(b) and Title 18, United States Code, Section 220(e)(3).

23 19. Commercial Insurers often made payments directly to laboratories and other providers,  
24 rather than to members who received the health care benefits, items, and services.

25 20. To obtain payment for treatment or services provided to a member, laboratories and other  
26 providers were required to submit itemized claim forms to the member's commercial insurance plan. The  
27 claim forms were typically submitted electronically. The claim form required certain important  
28 information, including: the member's name and identification number; a description of the health care

1 benefit, item, or service that was provided or supplied to the member; the billing codes for the benefit,  
2 item, or service; the date upon which the benefit, item, or service was provided or supplied to the member;  
3 and the name of the referring physician or other provider, as well as the applicable identification number  
4 for the referring physician or provider.

5 21. When a provider submitted a claim to Commercial Insurers, the provider certified that the  
6 contents of the form were true, correct, complete, and that the form was prepared in compliance with  
7 applicable laws and regulations. The provider also certified that the items or services being billed were  
8 medically necessary and were in fact provided as billed.

9 Diagnostic Testing

10 22. CMS regulated all laboratory testing (except research) performed on humans in the United  
11 States through the Clinical Laboratory Improvement Amendments (CLIA). All clinical laboratories  
12 seeking reimbursement were required to be properly certified by CLIA and state regulatory agencies.

13 23. Examples of clinical laboratory testing included the following:

14 a. Allergy testing: Allergy referred to conditions in which immune responses to  
15 environmental antigens caused tissue inflammation and organ dysfunction. Allergy testing was performed  
16 to determine immunologic sensitivity or reaction to antigens for the purpose of identifying the cause of  
17 the allergic state.

18 b. COVID-19 antibody testing: COVID-19 antibody testing was a test for antibodies  
19 in the blood to determine whether an individual was previously infected with the novel coronavirus disease  
20 2019, commonly referred to as “COVID-19.” COVID-19 antibody testing would not reliably diagnose a  
21 current COVID-19 infection.

22 24. Medicare did not cover diagnostic testing, including allergy and COVID-19 antibody  
23 testing, that was “not reasonable and necessary for the diagnosis or treatment of illness or injury or to  
24 improve the functioning of a malformed body member.” Title 42, United States Code, Section  
25 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover “examinations  
26 performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or  
27 injury.” Title 42, Code of Federal Regulations, Section 411.15(a)(1).



1 together with others known and unknown to the Grand Jury, engaged in a fraudulent scheme to obtain  
2 money and property by: (a) deceiving purchasers and sellers of Arrayit’s securities, and the market at-  
3 large, about the performance of Arrayit’s business, Arrayit’s financial condition, the nature and  
4 composition of Arrayit’s products, Arrayit’s sales, revenues, and expenses, and Arrayit’s prospects for  
5 growth; and (b) deceiving Medicare, Medicaid, TRICARE, and Commercial Insurers about insurance  
6 claims that SCHENA and his co-conspirators caused to be submitted to Medicare, Medicaid, TRICARE,  
7 and Commercial Insurers.

8 30. The purposes of the scheme to defraud were, among other things: (a) to promote Arrayit  
9 and SCHENA online and in public by overstating its status and influence; (b) to enrich SCHENA and  
10 Arrayit by increasing the company’s value and receiving additional revenue from Medicare, Medicaid,  
11 TRICARE, and the Commercial Insurers; and (c) to artificially increase and maintain the share price of  
12 Arrayit securities to, among other things, make Arrayit attractive to potential purchasers.

13 31. It was a part of the scheme that SCHENA and others used a variety of manners and means,  
14 including, among others:

15 a. Failing to provide investors and the SEC with accurate financial statements and  
16 reports of Arrayit’s financial condition;

17 b. Concealing Arrayit’s financial condition by falsely promising that the public  
18 release of Arrayit’s financial statements was imminent;

19 c. Making false and misleading statements to investors about the performance of  
20 Arrayit’s business, Arrayit’s financial condition, the nature and composition of Arrayit’s products,  
21 Arrayit’s sales, revenues, and expenses, and Arrayit’s prospects for growth;

22 d. Making false and misleading statements to investors about the proliferation of  
23 Arrayit’s proprietary allergy testing, and about “deals” and other agreements to spread Arrayit’s  
24 proprietary allergy testing;

25 e. Making false and misleading statements to investors about Arrayit’s plans to list on  
26 the NASDAQ stock exchange;

27 f. Making false and misleading statements to investors about Arrayit’s capability to  
28 test for COVID-19, the accuracy of Arrayit’s COVID-19 test, the status of its regulatory approval, and the

1 proliferation of Arrayit’s COVID-19 testing technology;

2 g. Manipulating the price of Arrayit stock through stock transfers and trading activity,  
3 and concealing securities transactions made in furtherance of the scheme;

4 h. Conspiring to defraud Medicare, Medicaid, TRICARE, and the Commercial  
5 Insurers, as discussed in greater detail in paragraphs 36 through 49; and

6 i. Concealing from investors, through false and misleading statements and omissions  
7 of material fact, Arrayit’s scheme to defraud Medicare, Medicaid, TRICARE, and the Commercial  
8 Insurers, and to illegally profit from the proceeds of illegal health care kickbacks and bribes.

9 32. It was further a part of the scheme to defraud that SCHENA and others took the following  
10 actions, among others:

11 a. On or about November 19, 2018, SCHENA issued a press release falsely stating  
12 that pursuant to “an allergy testing agreement,” Arrayit “is providing its proprietary microarray-based  
13 finger stick allergy testing services to Sutter Health via doctors in the Sutter Health-affiliated Palo Alto  
14 Medical Foundation,” Sutter Health, “one of the nation’s largest healthcare networks,” reports “total  
15 patient service revenues of \$12,000,000,000 annually.”

16 b. On or about August 8, 2019, SCHENA posted from the Arrayit Twitter account  
17 that “Arrayit clinical team commences \$240,000,000 test kit manufacturing run to build inventory for our  
18 rapidly expanding physician-ordered finger stick allergy testing services empowering clinic network  
19 doctors to identify, manage and treat allergy and asthma.” This false and misleading tweet was  
20 subsequently repeated elsewhere, including on social media and investor-focused message boards.

21 c. In early 2020, as COVID-19 began to spread around the world, SCHENA and  
22 Arrayit began promoting a test for COVID-19 through its website. SCHENA attempted to exploit the  
23 pandemic by claiming that Arrayit could test dried blood samples for both allergens and COVID-19, and  
24 instructing its patient recruiters and clinics to add on or bundle Arrayit’s allergy test and COVID-19 test  
25 regardless of medical necessity.

26 d. Between on or about March 19, 2020, and on or about March 21, 2020, SCHENA  
27 sent an email to dozens of investors who had inquired about the COVID-19 test. SCHENA’s email stated:  
28 “*Dear Valued Customer, We received more than 50,000 requests for our finger stick blood test for SARS-*

1 *CoV-2, the virus that causes coronavirus disease 2019 (COVID-19). Our team is coordinating with local,*  
2 *state and federal agencies and with our distributors to make this test available to as many patients as*  
3 *possible on an expedited timeline. Please consult our website and press releases for updates. Best regards,*  
4 *Arrayit Corporation.”* These false statements were subsequently amplified on social media and reposted  
5 on investor-focused message boards.

6 COUNT ONE: (18 U.S.C. § 1349 – Conspiracy to Commit Health Care Fraud and Wire Fraud)

7 33. The factual allegations in Paragraphs 1 through 32 are re-alleged and incorporated by  
8 reference as if fully set forth herein.

9 34. Beginning in or around 2018, and continuing through in or around June 2020, in the  
10 Northern District of California and elsewhere, the defendant,

11 MARK SCHENA,

12 did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine,  
13 conspire, confederate, and agree with others known and unknown to the Grand Jury to commit certain  
14 offenses against the United States, to wit:

15 a. to execute a scheme and artifice to defraud health care benefit programs affecting  
16 commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, Medicaid,  
17 TRICARE, and the Commercial Insurers, and to obtain by means of materially false and fraudulent  
18 pretenses, representations and promises, money and property owned by, and under the custody and control  
19 of, said health care benefit programs, in connection with the delivery of and payment for health care  
20 benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

21 b. by devising a scheme and artifice to defraud as to a material matter and to obtain  
22 money by means of materially false and fraudulent pretenses, representations, and promises, and for the  
23 purpose of executing the scheme and artifice, to knowingly transmit and cause to be transmitted by means  
24 of wire communication in interstate and foreign commerce, certain writings, signs, signals, pictures or  
25 sounds, in violation of Title 18, United States Code, Section 1343.

26 Purpose of the Conspiracy

27 35. It was a purpose of the conspiracy for SCHENA and his co-conspirators to unlawfully  
28

1 enrich themselves by: (a) submitting or causing the submission of false and fraudulent claims by interstate  
2 wire to Medicare, Medicaid, TRICARE, and the Commercial Insurers for services that were (i) procured  
3 by the payment of kickbacks and bribes; (ii) medically unnecessary; (iii) not eligible for reimbursement;  
4 and/or (iv) not provided as represented; (b) concealing the submission of false and fraudulent claims to  
5 Medicare, Medicaid, TRICARE, and the Commercial Insurers, and the receipt and transfer of the proceeds  
6 from the fraud; and (c) diverting proceeds of the fraud for their personal use and benefit, and to further  
7 the conspiracy.

8 Manner and Means

9 36. SCHENA and his co-conspirators used the following manner and means, among others, to  
10 accomplish the object and purpose of the conspiracy.

11 37. In or around May 2018, SCHENA and others announced that Arrayit had developed  
12 revolutionary new technology that allowed Arrayit to test for exposure to 120 common food and  
13 environmental allergens with only a single drop of blood from a finger stick sample.

14 38. SCHENA and others would apply for and maintain various laboratory certifications from  
15 state and federal agencies, including from CLIA, that were necessary for Arrayit to legally conduct testing  
16 and submit claims to Medicare, Medicaid, TRICARE, and Commercial Insurers.

17 39. SCHENA and others would submit or cause the submission of false and fraudulent  
18 attestations and other documents to state and federal regulators, including CLIA, that falsely certified the  
19 identity, roles, and responsibilities of Arrayit's laboratory director and other personnel, and concealed  
20 SCHENA's roles and responsibilities.

21 40. SCHENA and others would submit and cause the submission of false and fraudulent  
22 enrollment applications on behalf of Arrayit to Medicare, Medicaid, TRICARE, and Commercial Insurers,  
23 in which Arrayit certified that payment of claims was conditioned upon the underlying claims complying  
24 with the federal anti-kickback statute, the applicable laws, regulations, and program instructions, and that  
25 Arrayit would not knowingly present or cause to be presented false or fraudulent claims.

26 41. SCHENA and others paid and caused the offer and payment of illegal kickbacks and bribes  
27 to other individuals and purported marketing companies in exchange for blood samples collected from  
28 patients and orders for allergy testing from health care providers, all of which were used to support false

1 and fraudulent claims that were submitted by Arrayit and others to Medicare, Medicaid, TRICARE, and  
2 Commercial Insurers.

3 42. SCHENA and others distributed false and fraudulent marketing material and other  
4 documents that misrepresented the medical necessity of Arrayit's allergy test and Arrayit's ability to  
5 provide accurate, fast, and reliable allergy test results that would be medically necessary and reasonable  
6 in the treatment of the patient.

7 43. SCHENA and others caused Arrayit to test for 120 allergens regardless of the medical  
8 necessity, availability of the less expensive skin tests, reasonableness, rules against ordering the same test  
9 for each patient, or use of such testing in the treatment of each patient, in order to maximize the amount  
10 billed to Medicare, Medicaid, TRICARE, and the Commercial Insurers and allow SCHENA and others to  
11 issue positive financial projections for Arrayit that were deceptively based off the amount billed by  
12 Arrayit.

13 44. As the effects of the COVID-19 pandemic began to be felt in the United States and many  
14 patients faced difficulty obtaining access to COVID-19 testing, SCHENA and others used the COVID-19  
15 pandemic as an opportunity to expand the pre-existing allergy test scheme and to capitalize on a national  
16 emergency for their own financial gain by offering COVID-19 testing and bundling the COVID-19 test  
17 with, i.e., requiring combination with, Arrayit's more expensive allergy testing, which did not identify or  
18 treat COVID-19.

19 45. SCHENA and others obtained fraudulent orders for allergy and COVID-19 testing by  
20 making false and fraudulent statements, directly and indirectly, to health care providers, patients, and  
21 others concerning Arrayit's ability to provide accurate, fast, and reliable COVID-19 testing in compliance  
22 with applicable state and federal regulations, and the purported need to bundle the COVID-19 test with  
23 Arrayit's allergy test, while concealing that, at various times, the Arrayit COVID-19 test had not been  
24 developed, validated, produced, received the requisite regulatory authorization, or able to return timely  
25 COVID-19 results as represented.

26 46. SCHENA and others entered into sham contracts and agreements, and created and  
27 maintained false and fraudulent invoices and other documents, in order to conceal and disguise the illegal  
28 kickbacks and bribes, as well as that the testing was not provided as billed to Medicare, Medicaid,

1 TRICARE, and the Commercial Insurers, including concealing the ordering physician, medical clinic,  
 2 and/or laboratory that actually conducted the testing.

3 47. SCHENA and others caused Arrayit to submit approximately \$69 million in claims by  
 4 interstate wire to Medicare, Medicaid, TRICARE, and the Commercial Insurers for allergy tests that were  
 5 obtained through illegal kickbacks and bribes, medically unnecessary, ineligible for reimbursement,  
 6 and/or not provided as represented.

7 In violation of Title 18, United States Code, Section 1349.

8 COUNTS TWO THROUGH THREE: (18 U.S.C. § 1347 and 18 U.S.C. § 2 – Health Care Fraud)

9 48. The allegations in Paragraphs 1 through 32 and 36 through 47 are realleged and  
 10 incorporated as if fully set forth here.

11 49. On or about the dates set forth below, in the Northern District of California and elsewhere,  
 12 the defendant,

13 MARK SCHENA,

14 did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud health care  
 15 benefit programs as to a material matter and to obtain by means of materially false and fraudulent  
 16 pretenses, representations, and promises, and by concealment of material facts, money and property owned  
 17 by, and under the custody and control of, those health care benefit programs, all of the preceding in  
 18 connection with the delivery of, and payment for, health care benefits, items, and services:

COUNT	INSURED	INSURER	APPROXIMATE DATE OF SERVICE	SERVICES BILLED	APPROXIMATE AMOUNT BILLED
2	W.W.	Meritain Health	5/1/20	Allergy testing	\$5,293.28
3	T.M.	Medicare	5/13/20	Allergy testing	\$5,293.28

19 Each count a separate offense, in violation of Title 18, United States Code, Sections 1347 and 2.  
 20

21 COUNT FOUR: (18 U.S.C. § 371 – Conspiracy to Pay Kickbacks)

22 50. The allegations in Paragraphs 1 through 32 are realleged and incorporated as if fully set  
 23 forth here.  
 24

1 51. From in or around 2017, and continuing through in or around June 2020, in the Northern  
2 District of California and elsewhere, the defendant,

3 MARK SCHENA,

4 did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly combine,  
5 conspire, confederate, and agree with others, known and unknown to the grand jury, to commit certain  
6 offenses against the United States, that is: to violate Title 18, United States Code, Section 220(a)(2)(A),  
7 by offering and paying remuneration (including any kickback, bribe, or rebate) directly or indirectly,  
8 overtly or covertly, in cash or in kind, to induce a referral of an individual to a laboratory, with respect  
9 to services covered by a health care benefit program in and affecting interstate commerce.

10 Purpose of the Conspiracy

11 52. It was a purpose of the conspiracy for SCHENA and his co-conspirators to unlawfully  
12 enrich themselves by: (a) offering and paying kickbacks and bribes to induce the referral of members to  
13 Arrayit; (b) submitting or causing the submission of false and fraudulent claims to the Commercial  
14 Insurers for services that were procured by the payment of kickbacks and bribes; (c) concealing and  
15 causing the concealment of the submission of the kickbacks and bribes; and (c) diverting kickbacks and  
16 bribes, and the proceeds of the scheme, for their personal use and benefit, and to further the conspiracy.

17 Manner and Means

18 53. The allegations in Paragraphs 37 through 47 are realleged and incorporated as if fully set  
19 forth here.

20 Overt Acts

21 54. In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one of  
22 the co-conspirators committed and caused to be committed, in the Northern District of California and  
23 elsewhere, at least one of the following overt acts, among others:

24 55. On or about December 16, 2019, MARK SCHENA and others caused illegal kickback and  
25 bribe, in the approximate amount of \$19,289.74, to be paid to Marketer-1 in exchange for the referral of  
26 individuals to Arrayit.

27 56. On or about April 17, 2020, MARK SCHENA and others caused an illegal kickback and  
28 bribe, in the approximate amount of \$6,650.58, to be paid to Marketer-1 in exchange for the referral of

1 individuals to Arrayit.

2 In violation of Title 18, United States Code, Section 371.

3 COUNTS FIVE THROUGH SIX: (18 U.S.C. § 220(a)(2)(A) and 18 U.S.C. § 2 – Illegal Kickbacks)

4 57. The allegations in Paragraphs 1 through 32, 36 through 47, and 54 through 56 are realleged  
5 and incorporated as if fully set forth here.

6 58. From in or around 2017, and continuing through in or around June 2020, in the Northern  
7 District of California and elsewhere, the defendant,

8 MARK SCHENA,

9 did knowingly and willfully offer, pay, and cause to be offered and paid, any remuneration, including any  
10 kickback, bribe, and rebate, namely, the payments specified as to each count below, directly and indirectly,  
11 overtly and covertly, in cash and in kind, to induce a referral of an individual to a laboratory, that is,  
12 Arrayit, with respect to services covered by a health care benefit program, each in and affecting interstate  
13 and foreign commerce.

COUNT	RECIPIENT	APPROXIMATE DATE	AMOUNT
5	Marketer-1	12/16/19	\$19,289.74
6	Marketer-1	4/17/20	\$6,650.58

14  
15  
16  
17  
18  
19 Each count a separate offense, in violation of Title 18, United States Code, Sections 220(a)(2)(A)  
20 and 2.

21 COUNTS SEVEN THROUGH NINE: (15 U.S.C. §§ 78j & 78ff; 17 C.F.R. 240.10b-5; and 18 U.S.C. § 2  
22 – Securities Fraud)

23 59. The allegations in Paragraphs 1 through 32 are realleged and incorporated as if fully set  
24 forth here.

25 60. On or about the dates set forth below, in the Northern District of California and elsewhere,  
26 the defendant,

27 MARK SCHENA,

28 willfully and knowingly, directly and indirectly, by the use of the means and instrumentalities of interstate

1 commerce, the mails, and the facilities of national securities exchanges, in connection with the purchase  
 2 and sale of securities, did use and employ manipulative and deceptive devices and contrivances, and aided  
 3 and abetted others known and unknown to the grand jury, in violation of Title 15, United States Code,  
 4 Sections 78j and 78ff, Title 17, Code of Federal Regulations, Sections 240.10b5 and 240.10b5-2, and Title  
 5 18, United States Code, Section 2, by: (a) employing devices, schemes and artifices to defraud; (b) making,  
 6 and causing others to make, untrue statements of material facts and omitting to state material facts  
 7 necessary in order to make the statements made, in the light of the circumstances under which they were  
 8 made, not misleading; and (c) engaging in acts, practices and courses of business which operated and  
 9 would operate as a fraud and deceit upon persons; to wit, SCHENA used, and caused others to use, wires  
 10 and the mails to issue false and misleading statements related to Arrayit securities in the manner, and on  
 11 or about the dates listed, below:

COUNT	DATE	DESCRIPTION
SEVEN	11/19/18	SCHENA press release about “an allergy testing agreement” with multibillion-dollar company in Palo Alto, California
EIGHT	8/8/2019	SCHENA tweet about “\$240,000,000 test kit manufacturing run” disseminated to market
NINE	3/19/20	SCHENA emails to investors about demand for Arrayit’s COVID-19 tests and coordination with government agencies

17 Each count a separate offense, in violation of Title 15, United States Code, Sections 78j and 78ff,  
 18 Title 17, Code of Federal Regulations, Section 240.10b-5, and Title 18, United States Code, Section 2.

19 FORFEITURE ALLEGATION: (18 U.S.C. §§ 981(a)(1)(C) & 982(a) & 28 U.S.C. § 2461 –  
 20 Criminal Forfeiture)

21 61. The allegations in Paragraphs 1 through 60 are re-alleged and incorporated by reference  
 22 for the purpose of alleging forfeiture pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and  
 23 982(a), and Title 28, United States Code, Section 2461(c).

24 62. Upon conviction of any of the offenses alleged in Counts One through Nine, the defendant,  
 25  
 26 **MARK SCHENA,**  
 27 shall forfeit to the United States pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and  
 28 982(a), and Title 28, United States Code, Section 2461, any property, real or personal, which constitutes

1 or is derived from proceeds traceable to said violations, including but not limited to a sum of money equal  
2 to the total proceeds from the commission of said offense.

- 3 63. If, as a result of any act or omission of the defendant, any of said property
- 4 a. cannot be located upon the exercise of due diligence;
- 5 b. has been transferred or sold to or deposited with a third person;
- 6 c. has been placed beyond the jurisdiction of the Court;
- 7 d. has been substantially diminished in value; or
- 8 e. has been commingled with other property, which cannot be divided without difficulty;

9 the United States shall be entitled to forfeiture of substitute property, pursuant to Title 21, United States  
10 Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), and Title 28,  
11 United States Code, Section 2461(c).

12 All pursuant to Title 18, United States Code, Sections 981(a)(1)(C) and 982(a), and Title 28,  
13 United States Code, Section 2461.

14 DATED: May 18, 2020

A TRUE BILL

15  
16 /s/

17 \_\_\_\_\_  
FOREPERSON

18 STEPHANIE HINDS  
Acting United States Attorney

19 DANIEL KAHN  
Acting Chief, Fraud Section

20 /s/

21 \_\_\_\_\_  
22 WILLIAM FRENTZEN  
23 Assistant United States Attorney

24 /s/

25 \_\_\_\_\_  
26 JACOB FOSTER  
27 JUSTIN WEITZ  
Assistant Chiefs  
Fraud Section, Criminal Division

SEALED BY ORDER OF THE COURT

DEFENDANT INFORMATION RELATIVE TO A CRIMINAL ACTION - IN U.S. DISTRICT COURT

BY: [ ] COMPLAINT [ ] INFORMATION [ ] INDICTMENT [X] SUPERSEDING

OFFENSE CHARGED

Please see attached addendum.

- [ ] Petty
[ ] Minor
[ ] Misdemeanor
[X] Felony

PENALTY: Please see attached addendum.

Name of District Court, and/or Judge/Magistrate Location

NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION

DEFENDANT - U.S.

MARK SCHENA

DISTRICT COURT NUMBER
CR 20-00425-EJD

FILED

May 18 2021

SUSAN Y. SOONG
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO

PROCEEDING

Name of Complainant Agency, or Person (& Title, if any)

HHS-OIG; FBI; VA-OIG; USPI; DCIS

[ ] person is awaiting trial in another Federal or State Court, give name of court

[ ] this person/proceeding is transferred from another district per (circle one) FRCrp 20, 21, or 40. Show District

[ ] this is a reprosecution of charges previously dismissed which were dismissed on motion of:

[ ] U.S. ATTORNEY [ ] DEFENSE

SHOW DOCKET NO.

[ ] this prosecution relates to a pending case involving this same defendant

MAGISTRATE CASE NO.

[X] prior proceedings or appearance(s) before U.S. Magistrate regarding this defendant were recorded under

20-mj-70721

Name and Office of Person

Furnishing Information on this form STEPHANIE HINDS

[X] U.S. Attorney [ ] Other U.S. Agency

Name of Assistant U.S. Attorney (if assigned)

William Frentzen

DEFENDANT

IS NOT IN CUSTODY

- 1) [ ] Has not been arrested, pending outcome this proceeding. If not detained give date any prior summons was served on above charges
2) [ ] Is a Fugitive
3) [X] Is on Bail or Release from (show District) Northern District of California

IS IN CUSTODY

- 4) [ ] On this charge
5) [ ] On another conviction } [ ] Federal [ ] State
6) [ ] Awaiting trial on other charges
If answer to (6) is "Yes", show name of institution

Has detainer been filed? [ ] Yes [ ] No

If "Yes" give date filed

DATE OF ARREST Month/Day/Year

Or... if Arresting Agency & Warrant were not

DATE TRANSFERRED TO U.S. CUSTODY Month/Day/Year

[ ] This report amends AO 257 previously submitted

ADDITIONAL INFORMATION OR COMMENTS

PROCESS:

[ ] SUMMONS [X] NO PROCESS\* [ ] WARRANT

Bail Amount:

If Summons, complete following:

[ ] Arraignment [ ] Initial Appearance

Defendant Address:

\* Where defendant previously apprehended on complaint, no new summons or warrant needed, since Magistrate has scheduled arraignment

Date/Time: Before Judge:

Comments:

**Counts and Maximum Penalties:**

**COUNT ONE: 18 U.S.C. §§ 1349 - Conspiracy to Commit Health Care Fraud**

Penalties: Not more than 20 years imprisonment, not more than \$250,000 fine, not more than 3 years supervised release and \$100 assessment.

**COUNT TWO AND THREE: 18 U.S.C. § 1347 and 18 U.S.C. § 2 – Health Care Fraud**

Penalties: Not more than 10 years imprisonment, not more than \$5,000,000 fine, not more than 3 years supervised release and \$100 assessment.

**COUNT FOUR: 18 U.S.C. § 371 – Conspiracy to Pay Kickbacks**

Penalties: Not more than 5 years imprisonment, not more than \$250,000 fine, not more than 3 years supervised release, \$100 assessment.

**COUNTS FIVE THROUGH SIX: (18 U.S.C. § 220(a)(2)(A) and 18 U.S.C. § 2 – Illegal Kickbacks**

Penalties: Not more than 10 years imprisonment, not more than \$200,000 fine, not more than 3 years supervision, \$100 assessment.

**COUNTS SEVEN THROUGH NINE: (15 U.S.C. §§ 78j & 78ff; 17 C.F.R. 240.10b-5; and 18 U.S.C. § 2 – Securities Fraud**

Penalties: Not more than 20 years imprisonment, not more than \$5,000,000 fine, not more than 3 years supervision, and \$100 assessment.