

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,
INC.; UNITEDHEALTHCARE
INSURANCE COMPANY; AND UMR,
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES
SOUTHEAST, P.C.; INPHYNET
PRIMARY CARE PHYSICIANS
SOUTHEAST, P.C.; AND REDMOND
ANESTHESIA & PAIN TREATMENT,
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56 and Local Rules 7.1 and 56.1, Plaintiffs United Healthcare Services, Inc., UnitedHealthcare Insurance Co., and UMR, Inc. (collectively, "United") submit this Motion for Summary Judgment on all claims alleged in the Amended Complaint against the Defendants.

In support of this Motion, Plaintiffs file their accompanying Memorandum of Law, Statement of Undisputed Material Facts, and supporting declarations and exhibits thereto.

Dated: April 11, 2025

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CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing Motion for Summary Judgment to be filed with the Clerk of Court using the CM/ECF system, which will send a notification of such filing to all counsel of record.

This 11th day of April, 2025.

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INTRODUCTION

This declaratory judgment action seeks to resolve an ongoing and intractable dispute regarding the law that governs the payment of health claims by ERISA plans. Defendants routinely provide medical services to members of health plans that United administers in Georgia (the “Plans”), and contend that state common law requires United to pay 100% of Defendants’ unilaterally set billed charges without regard to Plan terms.¹ Officers with control over Defendants’ business practices have threatened to sue United if it does not pay Defendants’ claims in accordance with their view of state law (“Threatened Claims”),² and have refused to altogether withdraw those threats. At the same time, ERISA requires plan administrators (such as United) to adjudicate claims in accordance with Plan terms. United is thus in an impossible dilemma—if United adjudicates the claims in accordance with Plan provisions, it faces threatened litigation from Defendants. If United gives in to Defendants’ demands and pays their billed charges, United risks exposure to its clients for failing to follow Plan directives.

To ensure that Plans and their administrators do not face such an impossible

¹ This memorandum refers to Plaintiffs United HealthCare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. as “United.”

² More particularly, the Threatened Claims are claims that provisions or doctrines of Georgia state law other than contract principles—such as quantum meruit, state RICO laws, common law conversion, good faith and fair dealing, or consumer protection law—entitle Defendants to payment of their unilaterally determined billed charges. *See* Am. Compl. ¶¶ 10–12, 56–58, 83.

choice, but instead can adjudicate claims in a nationally uniform manner, ERISA explicitly preempts the exact types of Threatened Claims through its sweeping preclusion of any state law that “relates to” an ERISA plan. ERISA § 514(a), 29 U.S.C. § 1144(a). ERISA’s preemption provision is designed to prevent parties from circumventing Congress’s policy choice that a uniform body of federal law govern ERISA benefit determinations by artfully pleading state-law causes of action. The Threatened Claims here clearly “relate” to the Plans. Without any agreement between United and Defendants, the terms of the Plans themselves supply the only possible legal obligation for United to pay anything for Defendants’ services. Yet while the Threatened Claims depend entirely on the existence of a Plan, Defendants effectively seek to nullify Plan terms by requiring United to ignore the reimbursement amounts mandated by the Plans’ sponsors, and instead to reimburse claims at *higher* rates supposedly mandated by Georgia statutory or common law. The Threatened Claims, if allowed, would fundamentally rewrite the Plans’ allocation of payment responsibility between the Plans and their participants and beneficiaries, forcing United to provide more generous Plan benefit amounts—specifically, 100% of the providers’ unilaterally determined charges—than the Plans have agreed to cover.

A declaratory judgment action is the appropriate mechanism to resolve this ongoing legal dispute. There are no disputed issues of material fact, and the law is

clear: “[T]he payment of benefits” is quintessentially a “central matter of plan administration.” *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001), and thus Defendants may not use state law to require United “to structure benefit plans in particular ways.” *Rutledge v. Pharm. Care Mgmt. Ass’n.*, 592 U.S. 80, 86-87 (2020). United’s summary judgment motion should be granted, and the Court should issue a declaratory judgment that ERISA preempts the Threatened Claims.

BACKGROUND

United is a health insurer and a third-party claims administrator for certain ERISA-governed employee health benefit Plans whose members have sought services in Georgia. Declaration of Rebecca Paradise (“Paradise Decl.”) ¶¶ 3–4. When a participant in a Plan obtains covered healthcare services, United applies Plan terms to determine the benefit payment amount. *Id.* ¶¶ 7–15.

ERISA requires benefits under ERISA-governed plans to be administered according to plan terms. The statute allocates the responsibility for plan design to the plan sponsor (the employer), requiring the plan to “specify the basis on which payments are made to and from the plan,” and further requiring that the plan be administered “in accordance with the documents and instruments governing the plan.” 29 U.S.C. §§ 1102(b)(4), 1104(a)(1)(D); see *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) (“[E]mployers have large leeway to design disability and other welfare plans as they see fit.”). “The plan, in short, is at the

center of ERISA.” *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013); *see also Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 108 (2013) (“[T]he administrator’s duty is to see that the plan is ‘maintained pursuant to [that] written instrument,’” the plan document.).

Defendants are physician staffing companies owned by TeamHealth Holdings, Inc. that have provided emergency and non-emergency services in Georgia to participants in various Plans. Ex. 18; Answer ¶¶ 42, 44. The Plans provide that when participants obtain services from an in-network provider, the agreed rate is the “allowed amount” under the Plan, and the participants’ financial obligations (once deductibles are met) are limited to co-payments or coinsurance amounts that are small percentages of that allowed amount. Paradise Decl. ¶ 11. By contrast, when Plan participants obtain services from an out-of-network provider that does not have a negotiated rate with United, the “allowed amount” under the Plan’s terms may be less than the provider’s charge, and participants are responsible not only for applicable co-payments or coinsurance toward that amount, but also for any provider charges that exceed what the Plans cover. *Id.* ¶¶ 19–21. Plan sponsors typically prefer the certainty of agreed rates, and often design benefits to incentivize participants to use in-network providers. *Id.* ¶ 12.

Two of the Defendants and United were previously parties to a network participation agreement that set agreed rates for services. Ex. 14. On October 15,

2019, United terminated that network agreement because the parties could not agree upon rates of payment. Ex. 15. Defendants were thereafter free to charge Plan participants any rates that they chose, but with no guarantee that the Plans would pay any specific amount toward those charges—and with the prospect of having to pursue participants for the remaining balances. *Id.*; Paradise Decl. ¶ 16–18. Since the network agreement was terminated, however, TeamHealth has continued to insist that United alone is legally obligated to pay whatever amounts they unilaterally choose to bill patients, notwithstanding the Plans’ terms. Defendants’ demand contradicts United’s obligations as claims administrator to the Plans: Where there is no agreement with a provider, United’s obligation under ERISA is to pay the benefit amounts prescribed by the Plans. *Id.* ¶ 20. Under all Plans, the participant remains responsible for any further balances. *Id.* ¶ 21.

LEGAL STANDARD

Summary judgment is warranted when “there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a); *Hickson Corp. v. N. Crossarm Co.*, 357 F.3d 1256, 1259–60 (11th Cir. 2004). To defeat a properly supported motion, the non-moving party must adduce “specific facts” showing that there is a genuine issue for trial. *Walker v. Darby*, 911 F.2d 1573, 1576–77 (11th Cir. 1990). The Declaratory Judgment Act (“DJA”) allows a federal court, “[i]n a case of actual controversy within its

jurisdiction,” to “declare the rights ... of any interested party seeking such declaration.” 28 U.S.C. § 2201(a). Because DJA actions often involve “a somewhat hypothetical set of facts,” the threshold question is whether a justiciable controversy exists. *GTE Directories Publ’g Corp. v. Trimien Am., Inc.*, 67 F.3d 1563, 1569 (11th Cir. 1995). The mere “threat of future litigation” typically suffices to establish jurisdiction. *Nike, Inc. v. Already, LLC*, 663 F.3d 89, 96 (2d Cir. 2011), *aff’d*, 568 U.S. 85 (2013).

ARGUMENT

I. Undisputed Facts Establish a Live Dispute

The Court correctly denied Defendants’ motion to dismiss after concluding that United’s allegations established an ongoing controversy between the parties. Order Denying Motion to Dismiss (“Order”), ECF 43 at 7–11. The undisputed factual record now establishes the accuracy of the allegations in the Amended Complaint and confirms there is a live dispute between the parties.

At the outset, there is no dispute that Defendants have—after providing services to United members—submitted thousands of claims demanding payment from United at their full, unilaterally-determined billed charges. Exs. 31–36, Santos Decl. Table 4.³ Those demands are consistent with assertions by

³ This Court has diversity jurisdiction because Defendants admit that complete diversity exists here, *see* Answer, ECF No. 44, ¶ 23, and because the difference

TeamHealth’s senior officials that it is always entitled to its full billed charges from claims administrators like United. Ex. 19 at 80:15–81:14, Ex. 20 at 47:22–48:16, Ex. 21 at 318:3–319:2, Ex. 22 at 81:20–82:14; SUMF ¶¶ 82–90. Despite those demands, United has consistently followed its obligations to pay such claims consistent with applicable Plan terms. Exs. 16, 31–36; Santos Decl. Table 4. As this Court has recognized, this alone is sufficient to establish a live controversy:

[T]he Court is persuaded that this case presents a live controversy over the proper rate of reimbursement for out-of-network claims. Specifically, the controversy is whether United is obligated to pay 100% of the amounts billed by Defendants, or whether United may pay an amount that is consistent with the Plans.

Order at 11; *see State Farm Mut. Auto. Ins. Co. v. Bates*, 542 F. Supp. 807, 817 (N.D. Ga. 1982) (“Federal courts long have held that an insurance co. seeking determination of its liabilities . . . could utilize the [DJA] for such a purpose.”).

Nor is there any dispute that TeamHealth (which has full control over Defendants’ actions)⁴ has threatened litigation when United does not meet its demands to pay full billed charges and repeatedly followed through on those

between Defendants’ billed charges and the amount paid on behalf of the Plans vastly exceeds \$75,000. SUMF ¶¶ 71, 79. *See* 28 U.S.C. § 1332(a)(1).

⁴ As TeamHealth’s Senior VP Kent Bristow affirmed, he alone has “the authority to determine what reimbursement rates are acceptable to TeamHealth and its affiliates, including [Defendants], and whether to take legal action against health insurers and/or third-party administrators, such as United.” Declaration of Kent Bristow (“Bristow Decl.”), ECF 23-1 ¶ 7.

threats across the country. Exs. 26–28; SUMF ¶¶ 91–107. TeamHealth’s CEO boasted about these litigation threats during a failed negotiation with United:

We’ve gotten really good at the litigation route and have a template [complaint] to file in every state for every contract. . . . For every UHG termination, we’ll file a TeamHealth lawsuit.

Ex. 23. Thus, TeamHealth’s CEO has promised to file a lawsuit against United in *precisely* the circumstances present in Georgia: following termination of a network contract with a TeamHealth subsidiary. *Id.*; see Ex. 15; SUMF ¶¶ 98, 106–107.

Shortly after this action commenced, Mr. Bristow—the TeamHealth official with authority to initiate legal action against United—cemented that threat by expressly refusing to renounce litigation in Georgia. Bristow Decl. ¶ 8, Ex. 29–30; SUMF ¶¶ 108–110. He confirmed that TeamHealth may initiate suit against United in Georgia at any time based on its evaluation of unspecified “factors” and “conditions.” Ex. 30; SUMF ¶ 110. This Court correctly recognized that, in light of this declaration, “United has a reasonable apprehension that Defendants may bring an action in the future.” Order at 10–11.

United’s apprehension is all the more reasonable because TeamHealth has repeatedly made good on its threats by filing cases across the country when United terminates a network contract with a TeamHealth subsidiary. Exs. 26–28; SUMF ¶¶ 100–107. Indeed, since the letter terminating the network agreement encompassing two of the Defendants was sent in October 2019, TeamHealth

affiliates have sued United in four of the five other jurisdictions covered by the letter—peppering the suits over a four-year period. SUMF ¶ 107. As the Eleventh Circuit has recognized, a controversy is all the more concrete when, as here, the defendant has already sued on related claims. *GTE*, 67 F.3d at 1568–69.

The dispute is ongoing. The discovery record shows that Defendants have continued to demand full billed charges from United on recent claims. Exs. 31–36; SUMF ¶ 74. While the federal “No Surprises Act” (“NSA”) has recently channeled disputes over a large percentage of these claims to arbitration,⁵ United faces incremental exposure to Defendants’ Threatened Claims whenever the hospitals or other facilities at which Defendants provide services leave United’s contractual networks, even temporarily—as the NSA does not apply to non-emergent services provided at non-network facilities. 26 U.S.C. § 9816(a)(1); Paradise Decl. ¶ 16; Leach Decl. ¶ 5. United thus faces an ongoing dilemma of following the Plans’ reimbursement terms and courting litigation from Defendants, or acceding to Defendants and risking exposure to the Plans’ sponsors. The Court need only take TeamHealth’s CEO at his word to conclude that there is a live

⁵ 26 U.S.C. § 9816(c). In 2023, approximately 679,156 arbitration proceedings were initiated under the NSA. *See* Supplemental Background on Independent Dispute Resolution Public Use Files, July 1, 2023 – December 31, 2023, Centers for Medicare & Medicaid Services, *available at* <https://www.cms.gov/files/document/federal-idr-supplemental-background-2023-q3-2023-q4.pdf>. Claims subject to the NSA are excluded from this lawsuit. Am. Compl. ¶¶ 47–50.

controversy here. Ex. 23; SUMF ¶¶ 91–98; *see* Order at 8 (“Given this threat of litigation, the Court finds that United has shown that the controversy is of sufficient immediacy”); *GTE*, 67 F.3d at 1569 (threats of litigation sufficient to create a live controversy); *Gordon v. Auto-Owners Ins. Co.*, 2020 WL 2770169 at *3 (S.D. Ga. May 28, 2020) (same); *see also Nike*, 663 F.3d at 95–96 (same).

II. ERISA Expressly Preempts The Threatened Claims

ERISA’s express preemption clause provides that ERISA “shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan.” ERISA § 514(a), 29 U.S.C. § 1144(a). Defendants’ Threatened Claims plainly “relate to” the ERISA-governed Plans that United administers in Georgia and are therefore preempted by ERISA under well-established principles.

A. ERISA’s Express Preemption Clause Precludes State Law Claims That “Relate To” an ERISA-Governed Benefit Plan

“The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Congress ensured uniform nationwide regulation by expressly superseding any state law that “relate[s] to” an ERISA-governed benefit plan. ERISA § 514. The Supreme Court has repeatedly declared that this clause is “expansive” and of “conspicuous [] breadth.” *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138–39 (1990). Particularly suspect are laws that “interfere[] with nationally uniform plan administration,” or that “force an ERISA plan to adopt a certain scheme of

substantive coverage.” *Rutledge*, 592 U.S. at 87; *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016) (same). Importantly, ERISA supersedes not only state regulations but also state common law claims that seek to override or supplement the terms of a plan, including claims that “interfere with the calculation of benefits owed.” *Chau v. Hartford Life Ins. Co.*, 167 F. Supp. 3d 564, 571 (S.D.N.Y. 2016).⁶

B. Defendants’ Threatened Claims Plainly “Relate To” United’s ERISA-Governed Plans

State laws “relate to” ERISA plans where they have either an “impermissible connection with” or an impermissible “reference to” the plans. *Gobeille*, 577 U.S. at 319–320. A state law has an impermissible “connection with” ERISA plans where it “governs . . . a central matter of plan administration” or “interferes with nationally uniform plan administration.” *Egelhoff*, 532 U.S. at 148. “[C]onnection with” preemption may also apply where “‘acute, albeit indirect, economic effects’ of the state law ‘force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.’” *Gobeille*, 577 U.S. at 320 (quoting *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995)). Separately, a state law has an impermissible “reference to” ERISA if it “acts immediately and exclusively upon ERISA plans”

⁶ See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47–48, 57 (1987); *Amos v. Blue Cross-Blue Shield of Ala.*, 868 F.2d 430, 431 (11th Cir. 1989) (same).

or “the existence of ERISA plans is essential to the law’s operation.” *Id.* (cleaned up). The Threatened Claims trigger both strands of ERISA express preemption.

First, the Threatened Claims have an impermissible “connection with” the United Plans because they invade a “central matter of plan administration.” Claim adjudication and payment—the determination of benefit amounts under a plan—represent the core function of “plan administration.” *Egelhoff*, 532 U.S. at 147–48. Here, Defendants’ Threatened Claims invade this core function by seeking to dictate benefit levels under the Plans—specifically, the portion of an out-of-network provider’s billed charges that the Plans must cover for their participants. Every United Plan addresses the amount of reimbursement the Plan will pay for covered out-of-network services, but none provides that the Plan will pay 100% of providers’ full, unilaterally determined billed charges. Paradise Decl. 24–36; Exs. 1–13; SUMF ¶¶ 23–61. Through their Threatened Claims, Defendants seek to override that benefit structure.

For example, the Ryder Plan expressly requires the Plan to reimburse the provider for certain out-of-network claims “based on 110% of the published rates allowed by [] Medicare for the same or similar service.” Ex. 9 at 81–82. This structural feature is common in United Plans that offer network and out-of-network benefits, as well as in ERISA plans generally. Paradise Decl. ¶ 24. And for good reason: As courts have noted, by offering superior coverage to participants that

obtain services within the provider network, Plans create an economic incentive for members to use the provider network, where the Plan and its participants benefit from negotiated rates. *Id.* ¶ 12; *see, e.g., Palmyra Park Hosp. Inc. v. Phoebe Putney Mem’l Hosp.*, 604 F.3d 1291, 1295 (11th Cir. 2010). Yet Defendants demand payment of their full, unilaterally-determined billed charges (which are many multiples of the Medicare rate), thus overriding Plan terms that allocate to the *participant* responsibility for charges above the Medicare rate—and eliminating the economic incentive for participants to seek services within the Plan’s provider network. Paradise Decl. ¶ 12; Santos Decl. ¶¶ 12–13; Exs. 31–36.

Defendants thus effectively seek to force the Plans “to adopt a certain scheme of substantive coverage,” and to “prohibit employers from structuring their [health] benefit plans in [their selected manner].” *Pharm. Care Mgmt. Ass’n v. Mulready*, 78 4th 1183, 1198–1200 (10th Cir. 2023). Such uses of state law to effectively amend or modify plan terms represent a special threat to ERISA’s goals and fall within the core of the statute’s express preemption clause.⁷ One of the central aims of ERISA’s express preemption clause is to further Congress’s

⁷ *See De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815 (1997) (ERISA § 514 preempts laws that regulate a plan’s “method of calculating ... benefits”); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (ERISA preempts any state law that requires a plan “to pay employees specific benefits.”); *Egelhoff*, 532 U.S. at 147 (same); *Wong, as Tr. of Anaplex Corp. Emp. Stock Ownership Plan v. Flynn-Kerper*, 999 F.3d 1205, 1207 (9th Cir. 2021) (same).

objective of facilitating “nationally uniform plan administration.” *Egelhoff*, 532 U.S. at 148. Allowing the Threatened Claims to escape ERISA preemption would plainly undermine that interest. If, as TeamHealth insists, United must adjudicate benefit amounts according to state law standards, including the varying standards of state common law, then the Plans’ payment obligations will vary from state to state, making it impossible for United to administer Plan terms in a consistent fashion. *See Pharm. Care Mgmt. Ass’n v. Rowe*, 429 F.3d 294, 302 (1st Cir. 2005) (ERISA preemption implicated where state law “preclude[s] the ability of plan administrators to administer their plans in a uniform fashion.”).

Second, Defendants’ Threatened Claims also have an impermissible “reference to” the Plans. The claims depend on the “existence of ERISA plans,” *Gobeille*, 577 U.S. at 320, because any obligation that United may have to reimburse Defendants’ patients (or anyone else) for the costs of covered medical services arises from the Plans. *See Paradise Decl.* ¶ 20. If there is no Plan, or if a Plan does not cover the medical services at issue, there is no conceivable way Defendants could even purport to pursue the Threatened Claims against United. *Id.* As the Third Circuit explained in *Plastic Surgery Center, P.A. v. Aetna Life Insurance Co.* in holding that a non-contractual “unjust enrichment” claim was expressly preempted by ERISA, where an insurer or administrator’s asserted duties “arise specifically from plan provisions,” and “there simply is no cause of action []

if there is no plan,” the state law claim is “squarely preempted by [ERISA] section 514(a).” 967 F.3d 218, 239–42 (3d Cir. 2020) (citing *Ingersoll-Rand*, 498 U.S. at 140).⁸ The Eleventh Circuit applied this same logic in upholding an injunction against enforcement of a Georgia prompt payment law against ERISA plans. *See Am. ’s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324, 1331–32 (11th Cir. 2014); *Michael M. v. Nexsen Pruet Grp. Med. & Dental Plan*, 2021 WL 1026383, at *8 (D.S.C. Mar. 17, 2021) (same); *Catholic Diocese of Biloxi Supplemental Med. Reimbursement Plan v. Blue Cross, Blue Shield*, 960 F. Supp. 1145, 1151 (S.D. Miss. 1997) (same).

C. The Supreme Court’s Decision in *Rutledge* Does Not Save The Threatened Claims from ERISA Preemption

In unsuccessfully seeking dismissal of this action, Defendants argued that *Rutledge* pronounced that ERISA’s express preemption clause does not apply to any state laws that dictate the particular *amounts* that Plans must pay to providers unless they also dictate or proscribe the *specific services* for which Plans must

⁸ *See also Access Mediquip LLC v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 386–87 (5th Cir. 2011) (holding unjust enrichment and quantum meruit claims preempted because they “depend on its allegations that the ERISA plan would have obliged United to reimburse that other provider”); *Advanced Orthopedics and Sports Med. Inst., P.C. v. Oxford Health Ins., Inc.*, 2022 WL 1718052, at *3–8 (D.N.J. May 27, 2022) (providers’ promissory estoppel and unjust enrichment claims expressly preempted because the claims inescapably “flow[ed] from the insured’s plan” which provides a “lower level of benefits” than they demanded).

provide coverage. ECF 23 at 16–18. That is a profound misreading of *Rutledge*, which in fact reaffirmed the longstanding principles that support preemption here.

Rutledge involved a state law that directly regulated “pharmacy benefit managers” (“PBMs”), which are specialty service providers that health plans may retain to aid prescription drug delivery to plan members. 592 U.S. at 83–84.

Rutledge conceived of PBMs as facilitating the delivery of drug supplies to consumers through two distinct express contracts. On one side, according to *Rutledge*, a contract between the PBM and a pharmacy “set[s] reimbursement rates according to a list”—called a “formulary”—that specifies the maximum amount that the pharmacy will be paid for each listed drug. *Id.* at 84. On the other side, the Court posited, the PBM enters into contracts with health plans that specify “the amount that [the] plans reimburse” the PBM for any drugs that are dispensed to plan members. *Id.* The “difference” between those two amounts, according to *Rutledge*, is the PBM’s payment for its services and its profit. *Id.*

The state law reviewed by the *Rutledge* Court specified minimum amounts that pharmacies must be paid for their services, but the law ***did not*** regulate how payment responsibility to pharmacies was allocated among PBMs, plans, and plan participants, and ***did not*** require plans to pay any particular percentage or benefit amount. The law instead merely set “a floor” for the total “cost” of the covered prescriptions drugs—that is, “how much” a PBM “and its beneficiary . . . owe[.]”

Id. at 90; *see also id.* at 84. Nothing in the law would have prevented a plan, by its terms, from leaving its beneficiary to pay at the pharmacy counter all mandated costs above a fixed amount covered by the plan. The law thus did not “not require plans to provide any particular benefit to any particular beneficiary in any particular way.” *Id.* at 88–90. And although it was reasonable to expect that some of the increased costs associated with the pharmacy reimbursement minimums would be passed on to ERISA plans, “ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.” *Id.*

Rutledge’s holding thus did not upend the rules of ERISA preemption or break any new ground: to the contrary, it reaffirmed that state laws requiring plans “to structure benefit plans in particular ways” and “requiring payment of specific benefits” *by plans* are among the “primar[y]” targets of ERISA preemption. *Id.* at 86–87. Indeed, the Court declared that it was “decid[ing] th[e] case” based solely on “[t]he logic” of its decades-earlier and similarly-limited decision in *Travelers*. *Id.* at 88. In that earlier case, the Supreme Court rejected a preemption challenge to a New York statute that “require[d] hospitals to collect surcharges from patients.” 514 U.S. at 649–50. As New York explained in defense of the law, these “assessments [we]re not imposed upon ERISA plans,” and “the law d[id] not require any ERISA plan . . . to pay any benefit, any level of benefit, or any

particular amount of a patient’s hospital bill.” Br. for Pet’rs 18–19, *Travelers*, 1994 WL 646144 (U.S. Nov. 16, 1994). In fact, “at least one commercial insurer . . . made the determination that its plan terms d[id] not permit payment” of the surcharge. Reply Br. for Pet’rs 10 n.10, *Travelers*, 1994 WL 721247 (U.S. Dec. 29, 1994). As in *Rutledge*, therefore, *Travelers* upheld the state law at issue only after determining that the law “affect[ed] only indirectly the relative prices of insurance policies,” and “d[id] not bind plan administrators to any particular choice” or “preclude uniform administrative practice or the provision of a uniform interstate benefit package.” 514 U.S. at 659–60, 668.

In short, *Rutledge* was not a sea change in ERISA preemption, but rather a straightforward application of *Travelers*. Both precedents concerned a narrow category of state laws specifying the total costs due to providers from all sources, without compelling plans to pay particular amounts or provide particular benefits. But Defendants’ Threatened Claims are different—they have precisely the prohibited object of dictating the amounts that *the plans themselves* (or their administrators) alone must pay that the laws in *Rutledge* and *Travelers* lacked. The Threatened Claims would require United to defray Defendants’ unilaterally-set *billed charges*, even when those charges exceed the amount covered by the Plan. If credited, the Threatened Claims would thus prohibit United from applying Plan-approved reimbursement methodologies that limit out-of-network payments and

require the member to cover the balance, impeding the important plan design feature that encourages members to seek services from network providers.

By seeking to override United's administration of Plan terms and directly alter the Plan's benefit structure that allocates costs between health plans and their participants, Defendants' Threatened Claims go well beyond the narrow form of cost regulation that was held to survive preemption in *Rutledge* and *Travelers*.

III. The Court Should Exercise its Discretion to Clarify the Parties' Rights and Obligations

The Court should exercise its discretion to provide declaratory relief to clarify the legal relationship between the parties. United and TeamHealth are repeat players in the healthcare market with a fundamental disagreement about what law governs United's adjudication and payment of health Plan claims. The parties need to know whether United must: (i) pay the amount dictated by Plan documents (as required by ERISA § 404(a)(1)(D)) or (ii) instead cause the Plans to pay Defendants 100% of their unilaterally-determined billed charges. United believes the answer to that question is clear under the principles articulated by the Supreme Court. Nevertheless, trial court decisions are in disarray, and declaratory relief is required to settle the legal relationship between the parties.

A. The Confusion and Disarray Among Certain Trial Courts Addressing Coercive Claims Filed by Health Care Providers Reinforces the Need for Declaratory Relief

As Defendants argued in seeking dismissal, there are several trial court decisions on the books (in conflict with others) that have allowed providers to pursue state law claims against ERISA plans and their administrators, notwithstanding ERISA’s express preemption clause. Many of these decisions confuse and conflate the scope of ERISA *express* preemption (the doctrine in ERISA § 514 on which United relies) with the different scope of implied preemption under ERISA § 502—sometimes referred to as “complete preemption.” Declaratory relief can helpfully resolve this confusion for the parties here.

In addition to incorporating an express preemption clause in § 514, ERISA includes an extensive set of remedial provisions in § 502. Because Congress intended this “comprehensive remedial scheme” to provide the “exclusive” mechanism for enforcing ERISA, the Supreme Court has held that—independent of § 514’s express preemption provision—§ 502 “completely pre-empt[s]” any “state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy.” *Davila*, 542 U.S. at 209, 216–17. Because these state-law claims seek to overtake an exclusive federal remedy, they are “necessarily federal in character” and therefore “removable to federal court.” *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 60, 63–64 (1987).

By contrast, *express* preemption under § 514 derives from distinct principles, provides an affirmative defense to enforcement, and sweeps more broadly than complete preemption under § 502. *See Conn. State Dental Ass’n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1344 (11th Cir. 2009). Section 502(a) preempts only “remed[ies]” and does not preempt “independent legal dut[ies]” created by state law, *Aetna Health Inc.*, 542 U.S. at 210, whereas § 514 also targets the substantive duties underlying those remedies, *see, e.g., Pilot Life*, 481 U.S. at 48. Courts thus routinely find duties arising independently under state law to be preempted by § 514 when they interfere with ERISA plan design and administration. *See, e.g., id.* at 47–48; *Amos*, 868 F.2d at 431.

Given these differences and the federalism concerns around redirecting litigation from state to federal court, courts have recognized two main limitations on the “narrower” compass of § 502 preemption. *Conn. State Dental*, 591 F.3d at 1344. It applies only where (1) the provider “could have brought [its] claim under ERISA § 502(a)(1)(B)” (typically by being a lawful assignee of the plan member’s rights), and (2) “no legal duty (state or federal) independent of ERISA or the plan terms is violated.” *Davila*, 542 U.S. at 210. Based on this second limitation, a host of decisions have drawn a distinction between “*right* to payment” disputes turning on the interpretation of a plan’s coverage provisions rather than any independent legal duty (where § 502 preemption applies), and “*rate* of payment”

disputes hinging on the terms of a contract or promise independent of the ERISA plan and governed by state law (where § 502 preemption does not apply).⁹

That distinction makes sense in the context of § 502 because that preemption doctrine is premised on the fact that § 502 is meant to catalog the exclusive remedies for ERISA violations, and it therefore has no impact on violations of duties created by other sources of law that are not remediable under ERISA. By contrast, preempting independent state-law duties is *the* central purpose of § 514, and there are numerous cases where the Supreme Court has found such duties to be preempted by § 514. *See, e.g., Gobeille* 577 U.S. at 320 (collecting cases).

But courts and litigants have frequently confused the two distinct preemption doctrines,¹⁰ and a handful of courts have wrongly abstracted from limitations imposed on § 502 preemption a general principle that *no* form of ERISA preemption (including § 514 preemption) applies to a state law or claim that relates exclusively to the *amounts* or *rates* that plans must pay for covered

⁹ *See Conn. State Dental*, 591 F.3d at 1350 (noting that federal courts have used “the ‘rate of payment’ and ‘right of payment’ distinction [a]s a useful means for assessing [whether] claims [are] based upon a breach of an agreement separate from an ERISA plan”); *accord Plastic Surgery Ctr.*, 967 F.3d at 229–33; *Marin Gen. Hosp. v. Modesto & Empire Traction, Co.*, 581 F.3d 941 (9th Cir. 2009).

¹⁰ *See Marin Gen.*, 581 F.3d at 944–45 (“The parties in this case have not clearly understood the difference between complete preemption ... and conflict preemption under ERISA.”); *id.* at 945–46 (“prior opinions dealing with complete preemption ... have used the terminology ‘relate to’ even though that terminology is relevant to conflict preemption ... rather than complete preemption”).

services. *See, e.g., Surgery Ctr. of Viera, LLC v. Meritain Health, Inc.*, 2020 WL 7389987, at *8 (M.D. Fla. June 1, 2020), *report and recommendation adopted*, 2020 WL 7389447 (M.D. Fla. June 16, 2020). This makes no sense in the § 514 context: The “right” versus “rate” of payment distinction originated as a shorthand test for distinguishing bona fide disputes over the interpretation of ERISA plan terms (which may qualify for removal to federal court under § 502 “complete preemption”) from disputes over the interpretation of entirely separate agreements with providers that are governed by state law. The distinction has no proper bearing on the *express preemption* analysis under § 514 where there is no “agreement” other than an ERISA plan delineating the scope of the alleged indemnity and any independent non-contractual duties under state law interfere with the terms and design of the plan.¹¹

Such conflicts have appeared even in the same district. For instance, in *Surgery Center v. Meritain Health*, a court cited § 502 preemption cases for the conclusion that certain claims like those at issue here were not expressly preempted by § 514 because they were “more akin to a rate of payment dispute.” 2020 WL 7389987 at *8. By contrast, the court in *Surgery Center of Viera, LLC v.*

¹¹ *See Apex Toxicology, LLC v. United Healthcare Ins. Co.*, 2017 WL 7806152, at *8–9 (S.D. Fla. June 26, 2017) (finding rate versus right distinction inapposite in out-of-network provider context); *Alcalde v. Blue Cross & Blue Shield of Fla., Inc.*, 62 F. Supp. 3d 1360 (S.D. Fla. 2014) (same); *see also N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182, 201 (5th Cir. 2015) (same).

Cigna Health and Life Insurance Co., correctly reasoned that the “rate” versus “right” of payment distinction has no bearing on preemption under § 514, and went on to label the plaintiff’s contrary suggestion a “bait-and-switch” that “invites the Court into error by intentionally conflating the jurisdictional analysis necessary in removal cases with the ‘related to’ analysis appropriately applied to defensive preemption claims.” 2020 WL 4227428, at *2–3 (M.D. Fla. July 23, 2020).¹²

The confusion of some trial courts on this issue and the uncertainty that it has created for United and other similarly situated health insurers provides a compelling justification to award the requested declaratory relief. *See, e.g., C.R. by and through Reed v. Noggle*, 559 F. Suppl. 3d 1323, 1342 (N.D. Ga. 2021).¹³

¹² *Accord Healthcare Ally Mgmt. of Cal., LLC v. UnitedHealthcare Servs., Inc.*, 2024 WL 4554060, at *8 (S.D. Fla. Oct. 23, 2024); *Nathaniel L. Tindel, M.D., LLC v. Excellus Blue Cross Blue Shield*, 2023 WL 3318489, at *4–5 & n.6 (S.D.N.Y. 2023); *York v. Ramsay Youth Servs. of Dothan*, 313 F. Supp. 2d 1275, 1280–1281 (M.D. Ala. 2004).

¹³ A handful of other courts have misinterpreted the Supreme Court’s decision in *Rutledge* to similarly endorse the conclusion that ERISA’s express preemption clause does not supersede state laws that dictate the amounts that plans must pay in benefits, so long as the state law does not also dictate the scope of covered services. *See Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2024 WL 4229902, at *8 (S.D.N.Y. Sept. 17, 2024); *Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 658 F. Supp. 3d 1250, 1259 (S.D. Fla. 2023); *Fla. Emergency Physicians Kang & Assocs., v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1299 (S.D. Fla. 2021). This reading of ERISA § 514 preemption is also without foundation. As explained earlier, *supra* p. 16–19, the central holding of *Rutledge* is that, while a state may regulate overall rates for goods and services, it cannot override plan limitations on payment amounts toward such charges or

B. Declaratory Relief Would be Valuable in Resolving Disputes Over Ongoing Claims Adjudication

A declaratory judgment would resolve past claims totaling millions of dollars. Santos Decl. Table 4. Defendants’ affiliates have already brought litigation against United in other states and Defendants could initiate similar litigation in Georgia.¹⁴ Exs. 26–28; SUMF ¶¶ 99–105. Recent claims reflect Defendants’ continuing demand for their full billed charges for non-emergency services at non-network facilities, outside the scope of the NSA. Ex. 16; Santos Decl. ¶ 13. United needs to know whether to pay these claims according to the Plans or at the amounts demanded by Defendants. As this Court previously recognized:

a judgment in this action would settle the controversy between the parties as to all Georgia claims. *Moreover, a declaratory judgment would clarify the legal relations at issue between the parties.*

Order at 14. That remains true today and United respectfully submits that declaratory relief is necessary and warranted in this case.

CONCLUSION

The Court should grant United’s motion for summary judgment.

“require plans to provide any particular benefit to any particular beneficiary in any particular way.” 592 U.S. at 83–84, 88–90; *Griffin v. AT&T Servs., Inc.*, 2023 WL 3213550, at *6 (N.D. Ga. Mar. 21, 2023) (“*Rutledge*, if anything, reinforces the notion that state laws cannot dictate ERISA-governed plan terms[.]”), *aff’d*, 2023 WL 8852925 (11th Cir. Dec. 21, 2023).

¹⁴ For example, the statute of limitations for claims for unjust enrichment and quantum meruit in Georgia is four years. *See* Ga. Code Ann. § 9-3-26.

Respectfully submitted,

Dated: April 11, 2025

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LOCAL RULE 7.1(D) CERTIFICATION

In accordance with L.R. 7.1(D), the undersigned counsel hereby certifies that, consistent with L.R. 5.1C, the foregoing document was prepared in Times New Roman font, 14 point.

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CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing to be filed with the Clerk of Court using the CM/ECF system, which will send a notification of such filing to all counsel of record.

This 11th day of April, 2025.

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**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,
INC.; UNITEDHEALTHCARE
INSURANCE COMPANY; AND UMR,
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES
SOUTHEAST, P.C.; INPHYNET
PRIMARY CARE PHYSICIANS
SOUTHEAST, P.C.; AND REDMOND
ANESTHESIA & PAIN TREATMENT,
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

**STATEMENT OF UNDISPUTED MATERIAL FACTS IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Pursuant to Federal Rule Civil Procedure 56 and Local Rule 56.1, Plaintiffs United Healthcare Services, Inc., UnitedHealthcare Insurance Co., and UMR, Inc. (collectively, "United") submit this statement of material facts as to which there is no genuine dispute.

A. United Administers Claims in Georgia Pursuant to Employee Benefits Plans Subject to ERISA

1. United is a health insurer and a third-party claims administrator for certain employee health benefit plans in Georgia (“the United Benefit Plans” or the “Plans”). Declaration of Rebecca Paradise (“Paradise Decl.”) ¶ 3.

2. The “United Benefit Plans” are employer- and employee-organization sponsored health benefit plans that provide health coverage to individuals who work or reside in Georgia, as well other individuals, who have received or may receive services in Georgia. Paradise Decl. ¶ 4.

3. The United Benefit Plans include two types of Plans, “fully insured” plans and “self-funded” or “self-insured” plans. Paradise Decl. ¶ 5.

4. For “fully insured” Plans, the employer or plan sponsor pays premiums for the employee and any related Plan participants to United, and United assumes the financial responsibility to make Plan payments for covered health services out of its own financial resources. *Id.*

5. For “self-funded” or “self-insured” plans, the Plan sponsor pays a fee to United to build and provide Plan participants access to networks of providers who have contractually agreed to discount their services to Plan participants and beneficiaries, to review and adjudicate claims, to maintain claim payment and other records, to communicate with Plan participants and beneficiaries, to handle appeals, and to provide other services, but the Plan sponsor—not United—is

ultimately financially responsible for paying the Plan's benefits for health care services covered by the Plan. Paradise Decl. ¶ 6.

6. Each United Benefit Plan is subject to a governing plan document that defines the benefits available under the Plan. Paradise Decl. ¶ 7.

7. The Plan document is the external-facing document that describes Plan terms to participants and beneficiaries. *Id.*

8. In the case of a fully-insured Plan for which United insures or underwrites benefits, the governing document is typically referred to as a "Certificate of Coverage" or "COC." Paradise Decl. ¶ 8.

9. For self-funded Plans, the governing document is typically referred to as a "Summary Plan Description" or "SPD." *Id.*

10. The applicable SPD or COC states which healthcare services are eligible for payments or reimbursement under the Plan (hereafter, "Covered Services"), subject to the applicable terms and conditions of the Plan. Paradise Decl. ¶ 9.

11. In addition, the applicable SPD or COC prescribes the methodologies that the Plan will apply to calculate the amounts that will be considered for coverage under the Plan ("Allowed Amounts" or "Eligible Expenses") when Plan participants or beneficiaries obtain Covered Services. Paradise Decl. ¶ 10.

12. In turn, the applicable SPD or COC states how much of the Allowed Amounts will be paid by the Plan, and how much will be the financial responsibility of the Plan participant or beneficiary in the form of co-payments, co-insurance, deductible amounts, and otherwise. Paradise Decl. ¶ 11.

13. All of these different Plan provisions—including provisions detailing the Covered Services, the Allowed Amounts and Eligible Expenses, and the allocations of financial responsibility between the Plan and the Plan participants or beneficiary—are selected by the Plan sponsor. Paradise Decl. ¶ 12.

14. The Plan sponsor works with United to consider the array of different options, some of which may be from a menu of different options offered by United, and some of which may be bespoke, in order to select the Plan terms that fit that Plan sponsor's needs and preferences. *Id.*

15. Plan sponsors typically prefer the cost certainty of agreed rates, and often design plan benefits to financially incentivize participants to use in-network providers. *Id.*

16. Plan sponsors that elect a fully-insured structure typically are able to choose among an array of COCs with varying benefit provisions that United offers to plan sponsors in a given state. Paradise Decl. ¶ 13.

17. Plan sponsors that elect a self-insured structure may either furnish United an SPD that was drafted by them without the involvement of United, or

they can work with United to generate an SPD with Plan terms that are consistent with the Plan sponsor's benefit preferences. Paradise Decl. ¶ 14.

18. For all self-funded Plans whose claims will be adjudicated on United's primary claim platform for private employer plans, referred to as "UNET," United also creates a separate document known as the Benefit Detail Report (the "BDR"), which is a document internal to United that is designed to reflect how claims will be processed in United's claim processing system. *Id.*

19. The BDRs reflect the Plan sponsor's benefit selections, reflecting the specific rates or methodologies that the Plan sponsor has selected to be applied to calculate Allowed Amounts or Eligible Expenses. *Id.*

20. Information contained in the BDR is then programmed into United's claims processing system to ensure that claims are processed in accordance with the Plan. Paradise Decl. ¶ 15.

21. It is United's practice to have the Plan sponsor review the BDR to ensure that it accurately captures all of the benefit terms that the Plan sponsor has selected and directed United to apply. *Id.*

22. United also reviews the BDR to ensure that it is consistent with the terms of the SPD. *Id.*

B. The United Benefit Plans Dictate the Allowed Amounts for Covered Services Obtained from Out-Of-Network Providers

23. United Benefit Plans distinguish between two primary types of benefits: “network” benefits and “out-of-network” benefits. Paradise Decl. ¶ 16; Defendants’ Answer and Affirmative Defenses to Plaintiffs’ Am. Compl., ECF No. 44 (“Answer”) ¶ 35.

24. Network benefits refer to services delivered by a healthcare provider who has entered into a contract with United that specifies agreed reimbursement amounts for Covered Services. Paradise Decl. ¶ 16.

25. Healthcare providers who enter such agreements are known as “network” or “participating” providers. *Id.*

26. Out-of-network benefits refer to services provided by healthcare providers who do not have an agreement with United governing reimbursement amounts for Covered Services and are referred to as out-of-network providers. *Id.*

27. Hospitals and other facilities in Georgia occasionally terminate their participating provider agreements for various reasons, thus leaving United’s network of providers. Declaration of Valerie Leach ¶ 5; Paradise Decl. ¶ 16.

28. Sometimes, United is able to quickly come to terms with the departing hospital or facility on a mutually acceptable participating provider agreement, such that the loss of the provider from the network is temporary. *Id.*

29. At other times, the loss of the provider from the network is extended. *Id.*

30. Plan sponsors generally choose whether and in what circumstances out-of-network services are Covered Services under the Plan. Paradise Decl. ¶ 19.

31. If they are, United offers for Plan sponsor selection a menu of available out-of-network programs that prescribe how Allowed Amounts or Eligible Expenses for out-of-network services are calculated. *Id.*

32. Plan sponsors choose the method by which Allowed Amounts or Eligible Expenses will be calculated and applied to these services, and how much of the Allowed Amounts or Eligible Expenses will be paid by the Plan versus by the Plan participant or beneficiary by selecting one of these out-of-network programs. *Id.*

33. After the Plan sponsor makes a selection, United reviews the SPD to confirm that the sponsor's choice is consistent with the SPD and, if necessary, recommends updates to the SPD to ensure that the Plan terms are consistent with the Plan sponsor's benefit selections. *Id.*

34. When a participant or beneficiary receives Covered Services from an out-of-network provider, United causes the Plan to pay all or a plan-prescribed portion of the Allowed Amount or Eligible Expense that is calculated in

accordance with the rates or methodologies that the Plan sponsor has selected for the Plan. Paradise Decl. ¶ 20.

35. In this context, where there is no agreement with a provider, United's obligation as claims administrator under ERISA is to pay the benefit amounts prescribed by the Plans. *Id.*

36. When obtaining Covered Services from an out-of-network provider, the participant remains financially responsible to the out-of-network provider for any amounts that exceed the portion of the Allowed Amount or Eligible Expense that is payable under the Plan pursuant to the benefit structure approved by the Plan's sponsor (in addition to any applicable co-payments or co-insurance). Paradise Decl. ¶ 21.

37. For example, the Ryder Plan SPD states that when a Plan participant (other than one eligible for Medicare) receives non-emergency services from an out-of-network provider, "Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either United Healthcare or one of United Healthcare's vendors, affiliates, or subcontractors, at United Healthcare's discretion. If rates have not been negotiated, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of 50% of CMS for the same or similar

laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates. When a rate is not published by CMS for the service, United Healthcare uses an available gap methodology to determine a rate for the service as follows: For services other than Pharmaceutical Products, United Healthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk, and resources of the service. If the relative value scale(s) currently in use becomes no longer available, United Healthcare will use a comparable scale(s). United Healthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to United Healthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.” Ex. 9 at 81–82; Paradise Decl. ¶ 25.

38. The SPD further states that “[w]hen a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.” Ex. 9 at 82; Paradise Decl. ¶ 25.

39. Separately, the Ryder Plan SPD states that, when a member receives care that qualifies as an emergency service, the Eligible Expense is “an amount negotiated by United Healthcare or an amount permitted by law,” and states that

the “Plan will not pay excessive charges or amounts [the member is] not legally obligated to pay.” Ex. 9 at 81; Paradise Decl. ¶ 26.

40. The BDR for the Ryder Plan reflects the sponsor’s selection of a protocol identified as “F – SSP Fee Negotiations & Discount and OCM / No Facility R&C” to implement the Plan’s choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 13 at 4; Paradise Decl. ¶ 27.

41. Under this protocol, based on Ryder’s election, where a member is treated by an out-of-network provider in an emergency or in other contexts where the member has no choice of provider, United may access Multiplan’s Wrap network, use Multiplan’s individual claim negotiation services to negotiate reimbursement, or access the Outlier Cost Management (“OCM”) program, which reimburses claims based on Multiplan’s proprietary methodology. Paradise Decl. ¶ 27.

42. And the protocol provides that where a member has elected to see an out-of-network provider, United may determine the Allowed Amount or Eligible Expense by accessing Multiplan’s Wrap network, using Multiplan’s individual claim negotiation services to negotiate reimbursement, or reimbursing the claim based on the Plan’s specified percentages of CMS payment rates in the Medicare

program (referred to in the BDR as Ryder’s Maximum Non-Network Reimbursement Program (“MNRP”)). *Id.*

43. The SPD for the Dollar Tree Management, Inc. Consumer Driven Health Plan provides the following description for determining Eligible Expenses for Covered Services delivered by out-of-network providers in situations where the member chooses to see a non-network provider: “When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on: Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare’s vendors, affiliates or subcontractors, at UnitedHealthcare’s discretion. If rates have not been negotiated, then one of the following amounts: For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.” Ex. 8 at 10–11; Paradise Decl. ¶ 28.

44. The SPD for the Dollar Tree Management, Inc. Consumer Driven Health Plan also states that “[w]hen Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare,” “Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. ... The Plan will not pay

excessive charges or an amount you are not legally obligated to pay.” Ex. 8 at 10; Paradise Decl. ¶ 29.

45. The BDR for the Dollar Tree Plan reflects the sponsor’s selection of a protocol identified as “E – SSP Fee Negotiations & Discount / Facility R&C \$500 O/P & \$5000 I/P and OCM” to implement the Plan’s choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 11 at 6; Paradise Decl. ¶ 30.

46. Under this protocol, based on Dollar Tree’s election, where a member is treated by an out-of-network provider in an emergency or in other contexts where the member has no choice of provider, United may determine Allowed Amounts or Eligible Expenses by accessing Multiplan’s Wrap network, using Multiplan’s individual claim negotiation services to negotiate reimbursement, or accessing the OCM program, which reimburses claims based on Multiplan’s proprietary methodology. Ex. 11 at 6; Paradise Decl. ¶ 30.

47. To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out-of-network provider, United may access Multiplan’s Wrap network, use Multiplan’s individual claim negotiation services to negotiate reimbursement, or reimburse the claim through the Physician R&C program (denoting “Reasonable and Customary” rates that draw upon a database

maintained by third party FAIR Health) at the plan sponsor-selected 80th percentile charge in the geographical area. Ex. 11 at 6; Paradise Decl. ¶ 30.

48. The SPD for the Delta Account-Based Health Plan sets out the following guidelines for reimbursing claims where members choose to seek out of network care: “Below is a summary of how UHC determines Eligible Expenses for non-network benefits:

- A negotiated rate for the service or supply may be agreed to between UHC and the Non-Network Provider. This negotiated rate is the Eligible Expense.
- If rates are not negotiated between UHC and the Non-Network Provider, then one of the following amounts is the Eligible Expense:
 - Under the DABHP network medical options, the Eligible Expenses for non-network services and supplies are based on 140% of the Medicare-allowable charge (published rates allowed by the Centers for Medicare and Medicaid Services (CMS)) for the same or similar service or supply within the geographic market. This is referred to as the MNRP fee limit. MNRP applies to most non-network medical services and supplies including hospital, physician, radiology and medical supply expenses, and other non-network expenses for Covered Services....

- If there is not an established Medicare-allowable charge, UHC uses an available ‘gap methodology’ to determine a rate for the service as follows: > For services other than Pharmaceutical Products*, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service.”

Ex. 1 at 89–90; Paradise Decl. ¶ 31.

49. In detailing Eligible Expenses for out-of-network Covered Services where members do not affirmatively elect to seek out-of-network care, the SPD for the Delta Account-Based Health Plan also explains that “[e]mergency care, certain services billed by a Network Provider (such as radiology and lab fees) or services coordinated in advance by UHC are paid as network benefits,” and directs participants to the earlier section of the SPD discussing “‘Allowed Amount’ under the ‘Network Benefits-UHC Choice Plus’ section[.]” Ex. 1 at 89–90; Paradise Decl. ¶ 32.

50. In turn, that section reads: “If you receive Covered Services from a Non-Network Provider that are ... [a]s a result of an Emergency, or ... [f]or radiology, anesthesiology, pathology, lab or assistant surgeons and your Network Provider bills for them, then the Allowed Amount is an amount determined by

United Healthcare (that may be lower than the provider's billed charges), unless a lower amount is negotiated or authorized by law. In this case, the Non-Network Provider should not, but may, bill you for the difference between the billed amount and the rate determined by United Healthcare.” Ex. 1 at 88; Paradise Decl. ¶ 32.

51. The BDR for the Delta Account-Based Health Plan reflects the sponsor's selection of a protocol identified as “F - SSP Fee Negotiations & Discount and OCM / No Facility R&C” to implement the Plan's choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 10 at 6; Paradise Decl. ¶ 33.

52. To determine the Allowed Amount or Eligible Expense for claims where a member is treated by an out of network provider in an emergency situation or in another context where the member did not have a choice of provider, based on Delta's elections, United may determine the Allowed Amount or Eligible Expense by accessing Multiplan's Wrap network, using Multiplan's individual claim negotiation services to negotiate reimbursement, or accessing the OCM program, which reimburses claims based on Multiplan's proprietary methodology. Ex. 10 at 6; Paradise Decl. ¶ 33.

53. To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out-of-network provider, United may access Multiplan's Wrap network, use Multiplan's individual claim negotiation services

to negotiate reimbursement, or reimburse the claim pursuant to Delta’s MNRP election—i.e., 140% of the Medicare charge or, if no appropriate Medicare charge is available, 60% of the provider’s billed charge. Ex. 10 at 6; Paradise Decl. ¶ 33.

54. The SPD for the Textron Medical Benefits Plan SPD provides that: “When you choose to seek services from a non-Network Provider, ... Eligible Expenses will be determined based on: 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market[.]” Ex. 3 at 23; Paradise Decl. ¶ 34.

55. The SPD also further states: “When a rate is not published by CMS for the service and a methodology does not apply to the service, the Eligible Expense is typically based on 20% of the provider’s billed charge.” Ex. 3 at 23.

56. Separately, the Textron Medical Benefits’ SPD states that “[when Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by United Healthcare (i.e., you do not choose to use a non-Network provider), Eligible Expenses are an amount negotiated by United Healthcare or an amount permitted by law. ... The Plan will not pay excessive charges or amounts you are not legally obligated to pay.” Ex. 3 at 23; Paradise Decl. ¶ 35.

57. The BDR for the Textron Plan reflects the sponsor’s selection of a protocol identified as “D - Outlier Cost Management (OCM) ONLY” to implement

the Plan's choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 12 at 5; Paradise Decl. ¶ 36.

58. To determine the Allowed Amount or Eligible Expense for claims where a member is treated by an out-of-network provider in an emergency setting or in another context in which the member does not have a choice of provider, based on Textron's elections, United may access the OCM program, which reimburses claims based on Multiplan's proprietary methodology. Ex. 12 at 5; Paradise Decl. ¶ 36.

59. To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out-of-network provider, the protocol selected by Textron calls for United to treat 110% of the Medicare-allowable charge as the Allowed Amount or Eligible Expense. Ex. 12 at 5; Paradise Decl. ¶ 36.

60. This charge is determined based on the published rates allowed by CMS for the same or similar service or supply within the geographic market per Textron's Maximum Non-Network Reimbursement Program (MNRP) election or, if no appropriate Medicare charge is available, 20% of the provider's billed charge. Ex. 12 at 5; Paradise Decl. ¶ 36.

61. These are typical examples of methodologies for determining Allowed Amounts and Eligible Expenses for out-of-network services that are specified in SPDs or COCs applicable to the fully-insured and self-insured Plans for which United administers claim. Paradise Decl. ¶ 24.

C. United Pays Claims Submitted by The TeamHealth Defendants for Out-Of-Network Services to Participants in the United Benefit Plans

62. TeamHealth Holdings, Inc. (“TeamHealth”) is an affiliated group of companies that purports to provide practice management services to medical professionals. Decl. of Kent Bristow in Support of Defs’ Mot. to Dismiss, ECF No. 23-1 (“Bristow Decl.”), ¶ 3.

63. Defendants Hospital Physician Services Southeast, P.C., InPhyNet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. are physician staffing companies affiliated with TeamHealth. Ex. 18, Georgia Secretary of State’s Corporations Division filings for Hospital Physician Services Southeast, P.C., Redmond Anesthesia & Pain Treatment, P.C., and InPhyNet Primary Care Physicians Southeast, P.C., bearing Bates stamps UHC0012111, UHC0012125, and UHC0012126; Answer ¶¶ 42, 44.

64. Defendants have contracted with Georgia hospitals such as Piedmont Augusta Hospital, Piedmont Walton Hospital, Doctors Hospital of

Augusta, and others, to provide medical care to patients in those facilities. Answer ¶ 4.

65. Defendants set their own billed charges for the healthcare services that they render at those facilities under the direction and control of TeamHealth's Kent Bristow. *Id*; Bristow Decl. ¶ 7.

66. Defendants have rendered emergency and non-emergency medical services in Georgia to participants in and beneficiaries of the United Benefit Plans. Answer ¶ 3.

67. Prior to October 2019, United and two of the Defendants (Hospital Physician Services Southeast, P.C. and Redmond Anesthesia & Pain Treatment, P.C.) were previously parties to a network participation agreement (the "Participation Agreement") setting agreed rates for reimbursement of services. Answer ¶ 44; Ex. 14, Medical Group Participation Agreement by and between United HealthCare Insurance Company, on behalf of its affiliates, and TeamHealth, on behalf of its affiliates, dated July 29, 2009, and amendments thereto, bearing Bates stamps UHC0011981 through UHC0012091.

68. On July 9, 2019, United terminated the Participation Agreement, effective October 15, 2019, and the agreement has not been renewed, reinstated, or otherwise replaced. Answer ¶ 44; Ex. 15, Notice of Termination letter dated July 9, 2019 ("July 2019 Termination Letter") from Angie Nierman,

UnitedHealthcare Vice President of National Provider Contracting to Kent Bristow, TeamHealth Senior Vice President of Revenue Management, bearing Bates stamps UHC0004783 through UHC0004785.

69. The July 2019 Termination Letter also noticed the termination of the network contracts of other TeamHealth providers in five other jurisdictions: Texas, Florida, New Jersey, Ohio, and New York. Ex. 15, July 2019 Termination Letter. Defendants were thereafter able to charge Plan participants any rates that they chose, but with no guarantee that the Plans would pay any specific amount toward those charges—and with the prospect of having to pursue participants for the remaining balances. Paradise Decl. ¶ 18.

70. Since October 15, 2019, the TeamHealth Defendants have been and currently are “out-of-network” providers with respect to the United Benefit Plans, meaning that they do not have a contract of any kind with United that governs the reimbursement of the services provided by the TeamHealth Defendants to participants in the United Benefit Plans. Answer ¶¶ 3, 45; *see also* Paradise Decl. ¶¶ 18, 20.

71. From July 1, 2019 to April 20, 2024, the TeamHealth Defendants have submitted to United millions of dollars in claims, at the billed charges they have determined unilaterally, for Covered Services provided to participants in United Benefit Plans on an out-of-network basis. Declaration of Joao C. Dos

Santos (“Santos Decl.”) ¶ 14, Table 4 (reporting approximately \$4.8 million in full-billed charges submitted by the defendants); *see also* Exs. 31–36; *see also* Declaration of E. Mayers ¶ 6; Declaration of R. Beck ¶¶ 7, 9, 11, 13.

72. This figure excludes claims that are subject to dispute resolution procedures specified in the No Surprises Act (“NSA”), Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. 1, 134 Stat. 1182, 2758–2890 (2020). Santos Decl. ¶ 9(xi), Table 2.

73. This figure also excludes fully insured claims adjudicated under state-specified law in Georgia similar to the NSA based on reason codes regardless of time period. *Id.* at ¶ 9(xii).

74. Even after January 1, 2022, the TeamHealth Defendants have continued to submit claims for their full billed charges for Covered Services to participants in United Benefit Plans on an out-of-network basis that are not subject to the NSA. Santos Decl. ¶¶ 12–13; Exs. 31–36.

75. Defendants have submitted their claims for payment from the United Benefit Plans at billed charges they have determined unilaterally. Exs. 31–36; Santos Decl. ¶¶ 12–14; Ex. 16, Provider Remittance Advices; Bristow Decl. ¶ 7.

76. Rather than pay Defendants’ claims at Defendants’ full billed charges, United has followed its obligations to pay the claims according to the

United Benefit Plan’s reimbursement terms, limiting coverage to the Allowed Amounts. Santos Decl. ¶¶ 10–14, Table 4; Exs. 31–36; Ex. 16.

77. Of the claims for Covered Services submitted by the TeamHealth Defendants over this period on an out-of-network basis, exclusive of NSA Claims, United has determined that the Plans’ Allowed Amounts for these out-of-network services totaled \$1,602,744. Santos Decl. ¶ 14, Table 4.

78. The TeamHealth Defendants’ total billed charges for those claims, by contrast, were \$4,772,662. *Id.*

79. There is, therefore, a difference of \$3,190,768 between the full billed charges sought by TeamHealth and the amount that United paid pursuant the United Benefit Plans. *Id.*

D. TeamHealth Disputes Any Payment of Less than 100% of its Full-Billed Charges

80. TeamHealth oversees negotiations with insurance companies, including United, related to billing and reimbursement on behalf of TeamHealth affiliated medical practices. Bristow Decl. ¶ 4.

81. TeamHealth has the authority to negotiate on behalf of Defendants with United related to billing and reimbursements. *Id.*

82. Kent Bristow, TeamHealth’s Senior Vice President, Revenue Management, has the power and “authority to determine what reimbursement rates

are acceptable to TeamHealth and its affiliates, including Defendants.” Bristow Decl. ¶ 7.

83. Mr. Bristow has “the authority to determine . . . whether to take legal action against health insurers and/or third-party administrators, such as United.” Bristow Decl. ¶ 7.

84. In litigation brought by TeamHealth against United in the Southern District of New York, Mr. Bristow testified that TeamHealth expects to be reimbursed for their full billed charges:

Q. So if they’re out of network, you would expect them to pay the full billed charges; is that correct?

A. Or a small discount off of those bill[ed] charges based upon, again, one of the numerous rental network agreements that we have in place that’s an option for the plan to access.

Q. And your – that’s your expectation for an out-of-network commercial payor, correct? They either pay your full billed charges or a small discount off of your full billed charges?

A. Yes, because we believe our full billed charges are a reasonable value for the services that we’re providing.

Ex. 19, *Emergency Physician Servs. of N.Y. v. UnitedHealth Group, Inc.*, (S.D.N.Y.) April 12, 2023 Deposition of K. Bristow at Tr. 80:15–81:14.

85. Similarly, in litigation brought by TeamHealth in Florida, Mr. Bristow testified that United must reimburse TeamHealth’s claims at 100% of their full billed charges:

Q. To be clear then, Mr. Bristow, you're saying that Gulf-To-Bay's position is United should have used 100 percent of Gulf-To-Bay's billed charges for purposes of calculating the allowed amount on the disputed claims in this case, correct?

A. Again, I believe we should have been paid our charges. . . . So, again, we believe they should have been paid our full billed charges, given that they're reasonable and or a small discount of those charges that were available through them, that they accessed frequently through the rental network agreements. That all claims should have been handled that way.

Ex. 20, *Gulf to Bay Anesthesiology Assoc. LLC v. UnitedHealthcare of Florida, Inc.* (Fl. Cir. Ct.), June 29, 2022 Deposition of K. Bristow at Tr. 47:22–48:16.

86. In other litigation against United, Mr. Bristow testified as a Fed. R. Civ. P. 30(b)(6) witness on behalf of TeamHealth that there is no amount below TeamHealth's full billed charges that would constitute a fair value:

Q. Sure. Is it Team Physicians' position that there is no amount or rate below billed charges for the at-issue claims that would constitute fair value?

A. In this situation in these circumstances for the claims that are -- that are at dispute, yes, I agree with that.

Q. There is none; it's billed charges and that's it, correct?

A. Given that it's the usual and customary charge, yes.

Ex. 21, *Fremont Emergency Servs. (Mandavia), Ltd v. UnitedHealth Group, Inc.* (D. Nev.), May 13, 2021 Deposition of K. Bristow at Tr. 318:3–319:2.

87. Paul Bevilacqua is the TeamHealth Vice President of Managed Care and the former Director of Reimbursement at TeamHealth. Ex. 22,

Emergency Physician Servs. of N.Y. v. Unitedhealth Group, Inc. (S.D.N.Y.), March 17, 2023 Deposition of P. Bevilacqua at Tr. 17:21–18:23.

88. Mr. Bevilacqua’s responsibilities included overseeing billing and reimbursements on the revenue side. *Id.* at Tr. 18:10–15.

89. Mr. Bevilacqua reports directly to Kent Bristow. *Id.* at Tr. 18:25–19:9.

90. Mr. Bevilacqua also testified that TeamHealth will always dispute health plan payments on out-of-network claims that amount to less than their full billed charges:

Q. So is it a practice that, whenever TeamHealth receives . . . less than full billed charges on an out-of-network claim, they will always dispute it?

A. Yes.

Id. at Tr. 81:20–82:14.

E. TeamHealth Has Both Threatened and, in Other States, Initiated Litigation Against United When United Paid Less than 100% of TeamHealth’s Full-Billed Charges

91. In April 2019, TeamHealth’s CEO, Leif Murphy, met with UnitedHealth Group’s Chief Strategy and Growth officer, Dan Schumacher. Ex. 23, April 18, 2019 Email; Ex. 24, Oklahoma Trial Tr. (Day 11) 75:6–76:7.

92. Following that meeting, Mr. Murphy wrote an email to a number of TeamHealth officials, including Mr. Bristow, in which he memorialized the

meeting with Mr. Schumacher. Ex. 23, April 18, 2019 Email; Ex. 24, Oklahoma Trial Tr. (Day 11) 87:10–21.

93. At the meeting, TeamHealth sought to reach a network agreement on a rate of reimbursement for TeamHealth providers that would be equal to 495 percent of Medicare’s charges. Ex. 24, Oklahoma Trial Tr. (Day 11) 83:4–84:1.

94. Mr. Schumacher responded to that demand by stating that United felt it was being exploited because it was paying more than other commercial payers. Ex. 24, Oklahoma Trial Tr. (Day 11) 90:6–16, 93:20–94:10.

95. Mr. Murphy explained that he had authority to bring additional lawsuits and, if the parties could not reach an agreement, TeamHealth was going to file additional lawsuits against United in other states. *Id.* at 88:19–89:4, 95:12–17.

96. According to Mr. Murphy’s email memorializing the meeting, he told Mr. Schumacher that TeamHealth intended to “pursue[] litigation as a strategy.” He also stated that “the public fight is going to be ugly.” Ex. 23, April 18, 2019 Email; Ex. 24, Oklahoma Trial Tr. (Day 11) 88:19–89:1, 95:6-11.

97. Mr. Murphy further informed United that TeamHealth has “gotten really good at the litigation route and have a template [complaint] to file in every state for every contract.” Ex. 23, April 18, 2019 Email.

98. Mr. Murphy asserted that “[f]or every UHG termination, we’ll file a TeamHealth lawsuit.” *Id.*

99. At the time of this April 2019 meeting, TeamHealth had already initiated 4 lawsuits against United across the country. Declaration of W. Pollak, at ¶ 7; Ex. 23, April 18, 2019 Email.

100. As of earlier this year, TeamHealth-affiliated providers have initiated at least 11 separate lawsuits against United in nine different states across the country. Bristow Decl. ¶ 10; Answer ¶¶ 9–10; *see* Exs. 26–28 (*Atl. ER Physicians Team Pediatric Assocs., PA v. UnitedHealth Grp., Inc.*, No. 1:20-cv-20083, ECF No. 2 (D.N.J. Dec. 21, 2020); *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, No. 0:20-cv-60757, ECF No. 27 (S.D. Fla. June 9, 2020); *Emergency Grp. of Ariz. Pro. Corp. v. United Healthcare Inc.*, No. 2:19-cv-04687, ECF No. 18 (D. Ariz. Aug. 9, 2019)); *see also* *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, No. 8:20-cv-02964 (M.D. Fla. Dec. 11, 2020); *Fremont Emergency Servs. (Mandavia) Ltd. v. UnitedHealth Grp., Inc.*, No. 2:19-cv-00832 (D. Nev. Jan. 7, 2020); *Buffalo Emergency Assocs., LLP v. UnitedHealth Grp., Inc.*, No. 1:19-cv- 01148 (W.D.N.Y. Aug. 26, 2019); *Emergency Care Servs. of Pa., P.C. v. UnitedHealth Grp., Inc.*, No. 1:19-cv-01195 (M.D. Pa. July 11, 2019); *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc.*, No. 17-CA-011207 (Fla. 13th Judicial Cir., Hillsborough Cnty Dec. 15, 2017); *Hill Country Emergency Med. Assocs., P.A. v. UnitedHealthCare Ins. Co.*, No. D-1-GN-19-

002050, (Travis Cnty Dist. Ct., Tx. Apr. 15, 2019); *Emergency Dep't Physicians P.C. v. United HealthCare, Inc.*, No. 2:19-cv-12052 (E.D. Mich. Jul. 10, 2019); *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, No. 2023-CA-016780 (Fla. 13th Judicial Cir., Hillsborough Cnty Nov. 21, 2023).

101. Before several of these lawsuits were filed by one or more TeamHealth providers, Mr. Bristow—and not the TeamHealth providers—sent a letter to United demanding full billed charges for the providers’ out of network services and threatening litigation. *See, e.g.*, Ex. 17.

102. In each of these cases, the TeamHealth affiliates seek to recover their full-billed charges from United. *See, e.g.*, Ex. 26, *Atl. ER Physicians Team Pediatric Assocs., PA*, at ¶ 322 (“United is liable to Plaintiffs for the full amount of Plaintiffs’ billed charges since Plaintiffs” left United’s network).

103. These cases include claims that provisions or doctrines of state law other than contract principles—such as unjust enrichment, quantum meruit, state RICO laws, civil conspiracy, good faith and fair dealing, or consumer protection law—entitle the affiliates to payment at their full-billed charges, regardless of the Plans’ benefit language. *See, e.g., id.* at ¶¶ 310–382; Ex. 27, *Fla. Emergency Physicians Kang & Assocs., M.D., Inc.*, at ¶¶ 169–240; Ex. 28, *Emergency Grp. of Ariz. Pro. Corp.*, at ¶¶ 186–233.

104. For example, in *Emergency Group of Arizona Professional v. United Healthcare Inc.*, TeamHealth-affiliated providers brought a state court action against United to recover 100% of their charges for out-of-network provider services, asserting causes of action for breach of the implied covenant of good faith and fair dealing, unjust enrichment, unfair competition, consumer fraud, and for a declaratory judgment under Arizona law, among other claims. Ex. 28 at ¶¶ 186–233.

105. Similarly, in *Florida Emergency Physicians Kang & Associates, M.D., Inc. v. United Healthcare of Florida, Inc.*, TeamHealth-affiliated providers brought claims against United for reimbursement of their full billed charges, alleging violations of Florida’s deceptive and unfair trade practices act, and causes of action for unjust enrichment and quantum meruit, among others. Ex. 27 at ¶¶ 169–240.

106. The July 2019 Termination Letter (which noticed the termination of network contracts with Hospital Physician Services Southeast, P.C. and Redmond Anesthesia and Pain Treatment, P.C.) also noticed the termination of the network contracts of other TeamHealth providers in five other jurisdictions: Texas, Florida, New Jersey, Ohio, and New York. Ex. 15, July 2019 Letter.

107. TeamHealth-affiliated providers have brought lawsuits against United in four of the five other jurisdictions encompassed by the July 2019

Termination Letter, and one such lawsuit was filed against United in Florida late in 2023. Ex. 26, *Atl. ER Physicians Team Pediatric Assocs., PA v. UnitedHealth Grp., Inc.*, No. 1:20-cv-20083, ECF No. 2 (D.N.J. Dec. 21, 2020); *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, No. 2023-CA-016780 (Fla. 13th Judicial Cir., Hillsborough Cnty Nov. 21, 2023); *Hill Country Emergency Med. Assoc. v. UnitedHealthCare Ins. Co.*, No. D-1-GN-19-002050, (Travis Cnty Dist. Ct., Tx. Apr. 15, 2019); *Emergency Dep't Physicians P.C.. v. United HealthCare, Inc.*, No. 2:19-cv-12052 (E.D. Mich. Jul. 10, 2019).

108. On January 1, 2023, Kent Bristow submitted a declaration in which he represented that “[p]resently, the Georgia Medical Groups have no intent to take legal action against United.” Bristow Decl. ¶ 8 (emphasis added).

109. On January 23, 2024, United sent Mr. Bristow a letter requesting that he sign a declaration retracting TeamHealth’s prior litigation threats and confirming that Defendants will not sue United using non-contractual state law causes of action to seek increased payments on any of the claims at issue in this lawsuit. Ex. 29, United’s January 23, 2024 Letter to K. Bristow.

110. On January 29, 2024, TeamHealth’s counsel responded to United’s letter confirming that Mr. Bristow had refused to sign the declaration and making clear that TeamHealth might direct Defendants to file suit in Georgia at any time

based on its evaluation of an unspecified “variety of factors” and “conditions.” Ex.
30, Plaintiffs’ Counsel January 29, 2024 Letter on Behalf of K. Bristow.

Dated: April 11, 2025

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*Attorneys for Plaintiffs United
HealthCare Services, Inc.,
UnitedHealthcare Insurance Company,
and UMR, Inc.*

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing to be filed with the Clerk of Court using the CM/ECF system, which will send a notification of such filing to all counsel of record.

This 11th day of April, 2025.

/s/ Greg Jacob

Greg Jacob (*pro hac vice*)

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**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,
INC.; UNITED HEALTHCARE
INSURANCE COMPANY; AND UMR,
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES
SOUTHEAST, P.C.; INPHYNET
PRIMARY CARE PHYSICIANS
SOUTHEAST, P.C.; AND REDMOND
ANESTHESIA & PAIN TREATMENT,
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

**DECLARATION OF REBECCA PARADISE IN
SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I, Rebecca Paradise, declare and state as follows:

1. I am employed by United HealthCare Services, Inc. ("UHS") as Vice President, Out-of-Network Payment Strategy for UHS and its affiliates.¹

2. I have been employed by UHS ("United") for approximately 28 years. For the last 10 years, I have been responsible for United's out-of-network payment strategy. My responsibilities include overseeing United's methodologies and

¹ "United" here refers to both United HealthCare Services, Inc. and United Healthcare Insurance Company, but does not include UMR.

analysis used for reimbursing out-of-network providers in accordance with the requirements of the various health benefit plans administered by United. In my role, I am familiar with United's out-of-network reimbursement programs, United's systems for paying claims, and health benefit plan terms. I submit this Declaration in support of United's Motion for Summary Judgment. I have personal knowledge of the following facts and, if called and sworn as a witness, could and would testify completely thereto.

3. United is a health insurer and a third-party claims administrator for certain health benefit plans in Georgia ("the United Benefit Plans" or the "Plans").

4. The United Benefit Plans are employer- and employee-organization sponsored health benefit Plans that provide health coverage to individuals who work or reside in Georgia, as well as to other individuals who have received or may receive health care services in Georgia.

5. The United Benefit Plans include two types of Plans. For "fully-insured" Plans, the Plan sponsor pays premiums for the employee and any related Plan participants to United, and United assumes the financial responsibility to make Plan payments for covered health services out of its own financial resources.

6. For "self-funded" (also known as "self-insured") Plans, the Plan sponsor pays a fee to United to build and provide Plan participants access to networks of providers who have contractually agreed to discount their services to

Plan participants and beneficiaries, to maintain claim payment and other records, to communicate with Plan participants and beneficiaries, to review and adjudicate claims, to handle appeals, and to provide other services, but the Plan sponsor—not United—is ultimately financially responsible for paying the Plan’s benefits for health care services covered by the Plan.

7. Each United Benefit Plan is subject to a governing Plan document that explains the benefits available to Plan participants. The Plan document is the external-facing document that describes Plan terms to participants and beneficiaries.

8. In the case of a fully-insured Plan, the governing Plan document is typically referred to as a “Certificate of Coverage” or “COC.” For self-funded Plans, the governing Plan document is typically referred to as a “Summary Plan Description” or “SPD.”

9. The applicable COC or SPD outlines which health care services are eligible for payments or reimbursement under the Plan (hereafter, “Covered Services”).

10. In addition, the applicable COC or SPD explains the methodologies that the Plan will apply to calculate the amounts that will be considered for coverage under the Plan (“Allowed Amounts” or “Eligible Expenses”) when Plan participants or beneficiaries obtain Covered Services.

11. The applicable COC or SPD also states how much of the Allowed Amounts will be paid by the Plan, and how much will be the financial responsibility of the Plan participant or beneficiary in the form of co-payments, co-insurance, deductible amounts, and otherwise.

12. All of these different Plan provisions—including the Covered Services, the Allowed Amounts and Eligible Expenses, and the allocations of financial responsibility between the Plan and the Plan participants or beneficiary—are selected by the Plan sponsor. The Plan sponsor works with United to consider the array of different options, some of which may be from a menu of different options offered by United, and some of which may be bespoke, in order to select the Plan terms that fit that Plan sponsor's needs and preferences. Plan sponsors typically prefer the cost certainty of agreed rates, and often design plan benefits to financially incentivize participants to use in-network providers.

13. Plan sponsors that elect a fully-insured structure typically are able to choose among an array of COCs with varying benefit provisions that United offers to plan sponsors in a given state.

14. Plan sponsors that elect a self-insured structure may either furnish United an SPD that was drafted by them without the involvement of United, or they can work with United to generate an SPD with Plan terms that are consistent with the Plan sponsor's benefit preferences. For all self-funded Plans whose claims will

be adjudicated on United's primary claim platform for private employer plans, "UNET," United also creates a separate document known as the Benefit Detail Report (the "BDR"), which is a document internal to United that is designed to reflect how claims will be processed in United's claim processing system. The BDRs reflect the Plan sponsor's benefit selections, including the specific rates or methodologies that the Plan sponsor has selected to be applied to calculate Allowed Amounts or Eligible Expenses.

15. Information contained in the BDR is programmed into United's claims processing system to ensure that claims are processed in accordance with the Plan. It is United's practice to have the Plan sponsor review the BDR to ensure that it accurately captures all of the benefit terms that the Plan sponsor has selected and directed United to apply. United also reviews the BDR to ensure that it is consistent with the terms of the SPD.

16. United Benefit Plans distinguish between two primary types of benefits: "network" benefits and "out-of-network" benefits. Network benefits refer to services delivered by a healthcare provider who has entered into a contract with United that specifies agreed reimbursement amounts for Covered Services. Healthcare providers who enter such agreements are known as "network" or "participating" providers. Out-of-network benefits refer to services provided by healthcare providers who do not have an agreement with United governing

reimbursement amounts for Covered Services and are referred to as out-of-network providers. In my experience, hospitals and other facilities in Georgia occasionally terminate their participating provider agreements for various reasons, thus leaving United's network of providers. Sometimes, United is able to quickly come to terms with the departing hospital or facility on a mutually acceptable participating provider agreement, such that the loss of the provider from the network is temporary. At other times, the loss of the provider from the network is extended. For example, based on information and belief, United did not have participating provider agreements with AdventHealth Redmond during the period December 4, 2023 through March 14, 2024. AdventHealth was, accordingly, treated as an out-of-network provider during this period.

17. Attached hereto as Exhibit 14 is a true and correct copy of an excerpt of the network participation agreement entitled the "Medical Group Participation Agreement" between United HealthCare Insurance Company and certain providers, including the Defendants in this action, dated July 29, 2009, and amendments thereto, full documents produced bearing Bates stamps UHC0011981 through UHC0012091 and UHC0011472 through UHC0011473.

18. That network participation agreement was terminated on July 19, 2019. Attached hereto as Exhibit 15 is a true and correct copy of a Notice of Termination letter dated July 9, 2019, bearing Bates stamps UHC0004783

through UHC0004785. Defendants were thereafter able to charge Plan participants any rates that they chose, but with no guarantee that the Plans would pay any specific amount toward those charges—and with the prospect of having to pursue participants for the remaining balances.

19. Plan sponsors generally choose whether and in what circumstances out-of-network services are Covered Services under the Plan. If they are, United offers for Plan sponsor selection a menu of available out-of-network programs that prescribe how Allowed Amounts or Eligible Expenses for out-of-network services are calculated. Plan sponsors choose the method by which Allowed Amounts or Eligible Expenses will be calculated and applied to these services, and how much of the Allowed Amounts or Eligible Expenses will be paid by the Plan versus by the Plan participant or beneficiary by selecting one of these out-of-network programs. After the Plan sponsor makes a selection, United reviews the SPD to confirm that the sponsor's choice is consistent with the SPD and, if necessary, recommends updates to the SPD to ensure that the Plan terms are consistent with the Plan sponsor's benefit selections.

20. When a participant or beneficiary receives Covered Services from an out-of-network provider, United causes the Plan to pay all or a portion of the Allowed Amount or Eligible Expense that is calculated in accordance with the rates or methodologies that the Plan sponsor has selected for the Plan. Where there

is no agreement with a provider, United's obligation as claims administrator under ERISA is to pay the benefit amounts prescribed by the Plans.

21. The participant remains financially responsible to the out-of-network provider for any amounts that exceed the portion of the Allowed Amount or Eligible Expense that is payable under the Plan pursuant to the benefit structure approved by the Plan's sponsor.

22. Attached hereto as Exhibits 1 to 9 are excerpts of true and correct copies of benefit Plan documents (SPDs and COCs) for certain Plans sponsored by the following employers: Delta Airlines, Duke Energy, Textron-Medical, FedEx Corporation, Insperity Holdings, Inc., Love's Travel Stops & Country Stores, Inc., Southwest Airlines Company, Dollar Tree Management, Inc., and Ryder System, Inc.. Also attached as Exhibits 10 to 13 are excerpts of true and correct copies of BDRs for a subset of these Plans that are self-insured.

Exhibit	Exhibit
1	Excerpt of the Delta Account-Based Healthcare Plan Healthcare Benefits Handbook, effective Jan. 1, 2019, full document produced bearing Bates numbers UHC0000465 through UHC0000828
2	Excerpt of the Duke Energy Retiree Medical Plan Standard PPO Option Benefit Booklet, effective Jan. 1, 2021, full document produced bearing Bates numbers UHC0005599 through UHC0005740
3	Excerpts of the Textron Medical Benefits, Textron HRA Plan, Textron Low Deductible-HSA Plan, Textron High Deductible-HSA Plan, Textron Maximum Deductible-HSA Plan Summary Plan Description, effective Jan. 1, 2020, full document produced bearing Bates numbers UHC0003942 through UHC0004134

Exhibit	Exhibit
4	Excerpts of the FedEx Corporation Summary Plan Description, effective Jan. 1, 2022, full document produced bearing Bates numbers UHC0006031 through UHC0006305
5	Excerpts of the Plan BCWN (Low) of Insperity Holdings, Inc. Summary Plan Description Certificate of Coverage, effective Jan. 1, 2021, full document produced bearing Bates numbers UHC0001798 through UHC0001991
6	Excerpts of the Love's Travel Stops & Country Stores, Inc. Employee Health Care Medical Plan B Summary Plan Description, effective Jan. 1, 2021, full document produced bearing Bates numbers UHC0009617 through UHC0009797
7	Excerpts of the Southwest Airlines Co. Welfare Benefit Plan Summary Plan Description, effective Jan. 1, 2019, full document produced bearing Bates numbers UHC0004998 through UHC0005197
8	Excerpts of the Dollar Tree Management, Inc. Bronze Plan Summary Plan Description, effective Jan. 1, 2019 and amended June 1, 2019, full document produced bearing Bates numbers UHC0003395 through UHC0003570
9	Excerpts of the Ryder System, Inc. Summary Plan Description, full document produced effective Jan. 1, 2018, bearing Bates numbers UHC0006306 through UHC0006588
10	Excerpts of the Benefit Detail Report for Delta Air Lines, Inc., last revised July 31, 2019, full document produced bearing Bates numbers UHC0010444 through UHC0010489
11	Excerpts of the Benefit Detail Report for Dollar Tree, Inc., last revised July 2, 2019, full document produced bearing Bates numbers UHC0010490 through UHC0010536
12	Excerpts of the Benefit Detail Report for Textron, last revised July 2, 2021, full document produced bearing Bates numbers UHC0010537 through UHC0010582
13	Excerpts of the Benefit Detail Report for Ryder System, Inc., last revised May 5, 2011, full document produced bearing Bates numbers UHC0010583 through UHC0010622

23. These Plan documents and BDRs are and were maintained in the ordinary course of United's regularly conducted business activities. These Plan

documents and BDRs correspond to the nine Plans which have been identified to me² as contributing the largest number of disputed claims submitted by Defendants for services rendered between July 1, 2019 and April 20, 2024, inclusive, and processed on United's UNET platform, excluding the Plan that UnitedHealth Group sponsors for employees of United and other subsidiaries. The nine Plans include several self-insured Plans and, in the case of the Plan sponsored by Insperity Holdings, a fully-insured Plan.

24. Based on my nearly 30 years of experience working at United, these Plan documents and BDRs contain typical examples of methodologies for determining Allowed Amounts and Eligible Expenses for out-of-network services that are specified in Plan documents applicable to the fully-insured and self-insured Plans for which United administers claim.

25. For example, the Ryder Plan SPD states that when a Plan participant (other than one eligible for Medicare) receives non-emergency services from an out-of-network provider, "Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either United Healthcare or one of United Healthcare's vendors, affiliates, or subcontractors, at United Healthcare's discretion. If rates have not been negotiated, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and

² See Declaration of Joao C. dos Santos, Section IV(E), ¶ 23.

Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of 50% of CMS for the same or similar laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates. When a rate is not published by CMS for the service, United Healthcare uses an available gap methodology to determine a rate for the service as follows: For services other than Pharmaceutical Products, United Healthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). United Healthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to United Healthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information." Ex. 9 at 81–82. The SPD further states: "When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge." *Id.* at 82.

26. Separately, the Ryder Plan SPD states that, when a member receives care that qualifies as an emergency service, the Eligible Expense is "an amount

negotiated by United Healthcare or an amount permitted by law,” and states that the “Plan will not pay excessive charges or amounts [the member is] not legally obligated to pay.” *Id.* at 81.

27. The BDR for the Ryder Plan reflects the sponsor’s selection of a protocol identified as “F – SSP Fee Negotiations & Discount and OCM / No Facility R&C” to implement the Plan’s choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 13 at 4. Under this protocol, based on Ryder’s election, where a member is treated by an out-of-network provider in an emergency or in other contexts where the member has no choice of provider, United may access Multiplan’s Wrap network, use Multiplan’s individual claim negotiation services to negotiate reimbursement, or access the Outlier Cost Management (“OCM”) program, which reimburses claims based on Multiplan’s proprietary methodology. And the protocol provides that where a member has elected to see an out-of-network provider, United may determine the Allowed Amount or Eligible Expense by accessing Multiplan’s Wrap network, using Multiplan’s individual claim negotiation services to negotiate reimbursement, or reimbursing the claim based on the Plan’s specified percentages of CMS payment rates in the Medicare program (referred to in the BDR as Ryder’s Maximum Non-Network Reimbursement Program (“MNRP”)).

28. The SPD for the Dollar Tree Management, Inc. Consumer Driven Health Plan provides the following description for determining Eligible Expenses for Covered Services delivered by out-of-network providers in situations where the member chooses to see a non-network provider: “When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on: Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare’s vendors, affiliates or subcontractors, at UnitedHealthcare’s discretion. If rates have not been negotiated, then one of the following amounts: For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.” Ex. 8 at 10–11.

29. The SPD for the Dollar Tree Management, Inc. Consumer Driven Health Plan also states that “[w]hen Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. ... The Plan will not pay excessive charges or an amount you are not legally obligated to pay.” *Id.* at 10.

30. The BDR for the Dollar Tree Plan reflects the sponsor’s selection of a protocol identified as “E – SSP Fee Negotiations & Discount / Facility R&C \$500 O/P & \$5000 I/P and OCM” to implement the Plan’s choices for determining

Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 11 at 6. Under this protocol, based on Dollar Tree's election, where a member is treated by an out-of-network provider in an emergency or in other contexts where the member has no choice of provider, United may determine Allowed Amounts or Eligible Expenses by accessing Multiplan's Wrap network, using Multiplan's individual claim negotiation services to negotiate reimbursement, or accessing the OCM program, which reimburses claims based on Multiplan's proprietary methodology. *Id.* To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out-of-network provider, United may access Multiplan's Wrap network, use Multiplan's individual claim negotiation services to negotiate reimbursement, or reimburse the claim through the Physician R&C program (denoting "Reasonable and Customary" rates based on benchmark data by third party, FAIR Health) at the plan sponsor-selected 80th percentile of billed charges in the geographical area. *Id.*

31. The SPD for the Delta Account-Based Health Plan sets out the following guidelines for reimbursing claims where members choose to seek out of network care: "Below is a summary of how UHC determines Eligible Expenses for non-network benefits: • A negotiated rate for the service or supply may be agreed to between UHC and the Non-Network Provider. This negotiated rate is the Eligible Expense. • If rates are not negotiated between UHC and the Non-Network

Provider, then one of the following amounts is the Eligible Expense: - Under the DABHP network medical options, the Eligible Expenses for non-network services and supplies are based on 140% of the Medicare-allowable charge (published rates allowed by the Centers for Medicare and Medicaid Services (CMS)) for the same or similar service or supply within the geographic market. This is referred to as the MNRP fee limit. MNRP applies to most non-network medical services and supplies including hospital, physician, radiology and medical supply expenses, and other non-network expenses for Covered Services.... - If there is not an established Medicare-allowable charge, UHC uses an available ‘gap methodology’ to determine a rate for the service as follows: > For services other than Pharmaceutical Products*, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service.” Ex. 1 at 89–90.

32. In detailing Eligible Expenses for out-of-network Covered Services where members do not affirmatively elect to seek out-of-network care, the SPD for the Delta Account-Based Health Plan also explains that “[e]mergency care, certain services billed by a Network Provider (such as radiology and lab fees) or services coordinated in advance by UHC are paid as network benefits,” and directs participants to the earlier section of the SPD discussing “‘Allowed Amount’ under

the ‘Network Benefits-UHC Choice Plus’ section[.]” *Id.* In turn, that section reads: “If you receive Covered Services from a Non-Network Provider that are ... [a]s a result of an Emergency, or ... [f]or radiology, anesthesiology, pathology, lab or assistant surgeons and your Network Provider bills for them, then the Allowed Amount is an amount determined by United Healthcare (that may be lower than the provider’s billed charges), unless a lower amount is negotiated or authorized by law. In this case, the Non-Network Provider should not, but may, bill you for the difference between the billed amount and the rate determined by United Healthcare.” *Id.* at 88.

33. The BDR for the Delta Account-Based Health Plan reflects the sponsor’s selection of a protocol identified as “F - SSP Fee Negotiations & Discount and OCM / No Facility R&C” to implement the Plan’s choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 10 at 6. To determine the Allowed Amount or Eligible Expense for claims where a member is treated by an out of network provider in an emergency situation or in another context where the member did not have a choice of provider, based on Delta’s elections, United may determine the Allowed Amount or Eligible Expense by accessing Multiplan’s Wrap network, using Multiplan’s individual claim negotiation services to negotiate reimbursement, or accessing the OCM program, which reimburses claims based on

Multiplan’s proprietary methodology. To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out of network provider, United may access Multiplan’s Wrap network, use Multiplan’s individual claim negotiation services to negotiate reimbursement, or reimburse the claim pursuant to Delta’s MNRP election—i.e., 140% of the Medicare charge or, if no appropriate Medicare charge is available, 60% of the provider’s billed charge. *Id.*

34. As a final example, the Textron Medical Benefits Plan SPD provides that: “When you choose to seek services from a non-Network Provider, ... Eligible Expenses will be determined based on: 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market[.]” Ex. 3 at 23. The SPD also further states: “When a rate is not published by CMS for the service and a methodology does not apply to the service, the Eligible Expense is typically based on 20% of the provider’s billed charge.” *Id.*

35. Separately, the Textron Medical Benefits Plan SPD states that “[w]hen Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by United Healthcare (i.e., you do not choose to use a non-Network provider), Eligible Expenses are an amount negotiated by United Healthcare or an amount permitted by law. ... The Plan will not pay excessive charges or amounts you are not legally obligated to pay.” *Id.*

36. The BDR for the Textron Medical Benefits Plan reflects the sponsor's selection of a protocol identified as "D - Outlier Cost Management (OCM) ONLY" to implement the Plan's choices for determining Allowed Amounts or Eligible Expenses for claims submitted by out-of-network providers in these different scenarios. Ex. 12 at 5. To determine the Allowed Amount or Eligible Expense for claims where a member is treated by an out-of-network provider in an emergency setting or in another context in which the member does not have a choice of provider, based on Textron's elections, United may access the OCM program, which reimburses claims based on Multiplan's proprietary methodology. To determine the Allowed Amount or Eligible Expense for claims where a member has elected to see an out-of-network provider, the protocol selected by Textron calls for United to treat 110% of the Medicare-allowable charge as the Allowed Amount or Eligible Expense. *Id.* This charge is determined based on the published rates allowed by CMS for the same or similar service or supply within the geographic market per Textron's Maximum Non-Network Reimbursement Program (MNRP) election or, if no appropriate Medicare charge is available, 20% of the provider's billed charge. *Id.*

37. After adjudicating a claim, United provides the provider with a "Provider Remittance Advice" or "PRA," which explains United's adjudication of the claim and summarizes the Allowed Amount or Eligible Expense for each

claim. Attached hereto as Exhibit 16 is a compilation of true and correct copies of PRAs issued by UnitedHealthcare Insurance Company to Hospital Physician Services Southeast, P.C., bearing Bates numbers UHC0010385, UHC0010438 through UHC0010439, and UHC0010390.

38. Attached hereto as Exhibit 17 is a compilation of two true and correct copies of letters issued by Health Care Financial Services of TeamHealth and received by UnitedHealthcare Services, Inc. and United Healthcare Insurance Company, bearing Bates numbers UHC0011188 through UHC0011193.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 11th day of April, 2025 in Minnetonka, Minnesota.

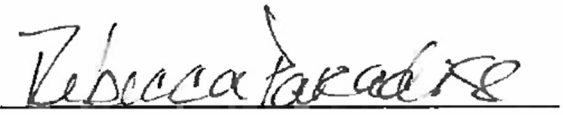

Rebecca Paradise

Exhibit 1



HEALTHCARE BENEFITS HANDBOOK: DELTA ACCOUNT-BASED HEALTHCARE PLAN

(Other Than PPO Option B, PPO Option B Out-Of-Area,
FDMO Options, Dental Option B and FDMO Dental Option)

FOR ACTIVE, INACTIVE, COBRA AND
CERTAIN RETIREE AND SURVIVOR PARTICIPANTS

Summary Plan Descriptions (SPD)
Effective as of January 1, 2019

WINNING TOGETHER
FOR YOUR HEALTH

Network and Non-Network Coverage Choices

Most Delta medical plans are network-based benefit options. They have network benefit coverage and non-network benefit coverage. In exchange for being a member of the UHC network, providers have agreed to contracted rates on their services, saving both you and Delta money. UHC offers an expansive network of doctors and health care professionals including clinics, labs and care centers, hospitals and pharmacies. Providers who are not part of the network (Non-Network Providers) have not agreed to contracted rates.

You pay less if you receive services from a Network Provider. If you see a Non-Network Provider for Covered Services instead of a Network Provider, the benefit paid by the plan is lower, and the amount you are responsible for is higher. The decision to use a Network Provider or a Non-Network Provider is always yours ... each time you need medical care.

Obtaining Discounted Services Out-Of-Area

The out-of-area medical options do not have network and non-network coverage because there is generally not a sufficient number of UHC Network Providers in locations where these options are offered. Instead, these medical options offer a uniform level of coverage. **However, there may be a few UHC Network Providers in your area who offer contracted rates on their services to UHC members, in which you can still benefit.**

Call the number on the back of your UHC ID card or visit **myuhc.com** to confirm whether a doctor or hospital is in the network — or simply ask your doctor. You may receive a list of Network Providers at no charge by contacting Delta Health Direct at **877-912-1820** or by going online to **myuhc.com** to print one.

Network Benefits – UHC Choice Plus

When you are enrolled in a network option (HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA) and use doctors, hospitals and other medical providers who are part of UHC's Choice Plus Network, network benefits apply. "Network benefits" mean that Covered Services are paid at a higher percentage after the annual Deductible. Another advantage to using Network Providers is that they usually handle any pretreatment approval when it is needed.

Reasons to Use Network Doctors

Save Money on Your Office Visits: You receive a contracted rate if you visit doctors and hospitals in the network. For example, while a non-network doctor may charge \$85 for an office visit, a network doctor may charge a contracted rate of \$65 for the same service.

Convenient Claims Submission: Network doctors submit claims on your behalf. Non-network doctors may or may not offer this convenience.

Access to Premium Providers: UnitedHealth Premium program evaluates doctors for quality of care and cost efficiency. The Premium designation helps you find doctors who meet national standards for quality and local market benchmarks for cost efficiency.

Allowed Amount

Network Providers have agreed to accept certain predetermined contracted fees as payment in full. This is known as the "Allowed Amount." More specifically, the Allowed Amount is defined as the negotiated amount of payment that a Network Provider has agreed to accept as payment in full for a Covered Service at the time your claim is processed.

Network benefit payments are based on UHC's Allowed Amount for medical expenses. When you use Network Providers, you only have to pay the Deductible and any Coinsurance amounts. With Network Providers, you are not responsible for any charges over the Allowed Amount.

If you receive Covered Services from a Non-Network Provider that are:

- Coordinated in advance by UHC,
- As a result of an Emergency, or
- For radiology, anesthesiology, pathology, lab or assistant surgeons and your Network Provider bills for them,

then, the Allowed Amount is an amount determined by UnitedHealthcare (that may be lower than the provider's billed charges), unless a lower amount is negotiated or authorized by law. In this case, the Non-Network Provider **should not**, but may, bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, contact Delta Health Direct at **877-912-1820**.

Find a Network Doctor, Hospital or Other Healthcare Professional on **myuhc.com**

- Find and compare network doctors and hospitals
- Save time with a list of the most commonly searched topics or find a doctor based on location, specialty, condition or procedure
- Search and compare hospitals on quality and cost of care for specific treatments
- Identify UnitedHealth Premium® designated network physicians who are recognized for high quality and efficiency of care

Step 1: Log on to **myuhc.com**

Step 2: Click the "Find a Doctor" button, or select "Find Care & Costs" from the menu bar

Step 3: Begin a medical, mental health or pharmacy directory search

Step 4: Follow the directions to search by people, places, services and treatments, care by condition or to access cost estimates

To search without logging in, go to **myuhc.com** and click on "Find Medical and Mental Health Providers and Facilities" under "Links and Tools". You also can call the number on the back of your UHC ID card. You also can receive a list of Network Providers at no charge by contacting Delta Health Direct at **877-912-1820**.

Non-Network Benefits

When you are enrolled in a network option and use doctors, hospitals and other medical providers who are not part of the UHC Choice Plus Network, non-network benefits apply. Non-network benefits pay a lower amount of the provider's submitted charges and you will be required to pay more out of pocket in most cases. You may check a provider's status in your area by visiting **myuhc.com** or by calling the "For Members" number on the back of your ID card.

You are responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services, for hospital pre-approval and for continued stay approval when necessary.

In addition, you generally pay more for a medical service when using a Non-Network Provider because he or she has not joined the network and therefore has not agreed to accept contracted fees. You are responsible for any amount over the "Eligible Expenses," which are determined by the claims administrator.

Gap Exception for Non-Network Providers

If you are enrolled in a network option, and you need to see a provider within a certain specialty but there is no Network Provider and/or facility within a 30-mile radius of your home ZIP Code, you may be eligible to receive benefits for certain Covered Services by a Non-Network Provider within that specialty at the network level. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this handbook. *You must call Delta Health Direct at 877-912-1820 to obtain such approval.*

Eligible Expenses for Non-Network Benefits

UHC, as the claims administrator, has the discretion and authority to decide whether a treatment or supply is a Covered Service and how the Eligible Expenses will be determined and otherwise covered under the HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options. For these options, UHC determines Eligible Expenses primarily using the Maximum Non-Network Reimbursement Program (MNRP). Under the MNRP, Non-Network Charges are based on a percentage of the federal Medicare-allowable charge for the applicable types of medical services and supplies. A Medicare-allowable charge is what the federal Medicare program would allow as a covered expense.

Below is a summary of how UHC determines Eligible Expenses for non-network benefits:

- A negotiated rate for the service or supply may be agreed to between UHC and the Non-Network Provider. This negotiated rate is the Eligible Expense
- If rates are not negotiated between UHC and the Non-Network Provider, then one of the following amounts is the Eligible Expense:
 - Under the DABHP network medical options, the Eligible Expenses for non-network services and supplies are based on 140% of the Medicare-allowable charge (published rates allowed by the Centers for Medicare and Medicaid Services (CMS)) for the same or similar service or supply within the geographic market. This is referred to as the MNRP fee limit. MNRP applies to most non-network medical services and supplies including hospital, physician, radiology and medical supply expenses, and other non-network expenses for Covered Services. (Note: Emergency care, certain services billed by a Network Provider (such as radiology and lab fees) or services

coordinated in advance by UHC are paid as network benefits; see "Allowed Amount" under the "Network Benefits– UHC Choice Plus" section above)

- If there is not an established Medicare-allowable charge, UHC uses an available "gap methodology" to determine a rate for the service as follows:
 - > For services other than Pharmaceutical Products*, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. Refer to UHC's website at **myuhc.com** for information regarding the vendor that provides the applicable relative value scale information
 - > For Pharmaceutical Products*, UHC uses gap methodologies that are similar to the pricing methodology used by Medicare, and produces fees based on published acquisition costs or average wholesale price of the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UHC based on an internally developed pharmaceutical pricing resource
- If an MNRP rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 60% of the provider's billed charge

UHC typically updates the CMS published rates within 30 to 90 days after updated CMS data becomes available.

You, as the covered participant, are required to pay 100% of the amount billed to you by the provider that is in excess of the Eligible Expense, because that excess amount is not covered by the plan. Only the amount you pay that is determined to be an Eligible Expense will be applied to your Deductible. Any charges in excess of Eligible Expenses are not covered by the plan so they are not applied to your Deductible or Coinsurance amounts and, therefore, can result in much higher costs to you than you may have anticipated. You are responsible for paying, directly to the Non-Network Provider, any difference between the amount the Non-Network Provider bills you and the amount UHC pays for Eligible Expenses.

Out-of-Area Benefits

When you are enrolled in an Out-of-Area Medical Option and receive Covered Services from a Non-Network Provider, the benefit level paid by the plan is the same as the benefit level for a Network Provider. However, Eligible Expenses for out-of-area benefits are calculated differently, and you may have higher out-of-pocket costs because Non-Network Providers have not agreed to accept contracted rates. You are responsible for any amount over Eligible Expenses, which are determined by the claims administrator.

You are also responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services, for hospital pre-approval and for continued stay approval when necessary.

Eligible Expenses for Out-of-Area Benefits

UHC, as the claims administrator, has the discretion and authority to decide whether a treatment or supply is a Covered Service and how the Eligible Expenses will be determined and otherwise covered under the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA Medical Options. For these options, UHC determines Eligible Expenses primarily using the Reasonable and

* Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Service by a physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the plan.

Customary (R&C) methodology. Under the R&C methodology, these benefit payments are based on a percentage of the R&C charge for a medical expense.

Below is a summary of how UHC determines Eligible Expenses for out-of-area benefits:

- A negotiated rate for the service or supply may be agreed to between UHC and the provider. This negotiated rate is the Eligible Expense
- If rates are not negotiated between UHC and the provider, then one of the following amounts is the Eligible Expense:
 - For services or supplies other than Pharmaceutical Products*, the Eligible Expenses are based on R&C charges, which UHC determines based on data resources of competitive fees in a geographic area. (Note: Emergency care or services coordinated in advance by UHC are paid as network benefits; see "Allowed Amount" under the "Network Benefits– UHC Choice Plus" section above)
 - For Pharmaceutical Products*, Eligible Expenses are based on 110% of the published rates for the federal Medicare-allowable charge for the item. A Medicare-allowable charge is what the federal Medicare program would allow as a covered expense for the same or similar service within a geographic market. If there is not an established Medicare-allowable charge, UHC will use "gap methodologies" that are similar to the pricing methodology used by Medicare and produce fees based on published acquisition costs or average wholesale price of the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomas Reuters* (published in its Red Book) or UHC based on internally developed pharmaceutical pricing resources

You, as the covered participant, are required to pay 100% of the amount billed to you by the provider that is in excess of the Eligible Expense, because that excess amount is not covered by the plan. Only the amount that you pay that is determined to be an Eligible Expense will be applied to your Deductible. Any charges in excess of Eligible Expenses are not covered by the plan so they are not applied to your Deductible or Out-of-Pocket Maximum and, therefore, can result in much higher costs to you than you may have anticipated. You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount UHC pays for Eligible Expenses.

* Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Service by a physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the plan.

Exhibit 2

Benefit Booklet

Duke Energy Retiree Medical Plan Standard PPO Option

Effective: January 1, 2021
Group Number: 729784



SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible, and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are

provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code. You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, UnitedHealthcare may require you to select a single Network Physician to provide and coordinate all future Covered Health Services. If you don't

make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the *SPD*.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts applies based on claim type:

- ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar freestanding laboratory service.
 - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
- ◆ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service location and resources of the service. The relative value may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Exhibit 3

TEXTRON MEDICAL BENEFITS

Textron HRA Plan

Textron Low Deductible-HSA Plan

Textron High Deductible-HSA Plan

Textron Maximum Deductible-HSA Plan

Administered by UnitedHealthcare

Summary Plan Description

For the following eligible employees:

- Textron Enterprise Non-Bargained Employees
- Certain Bargained Employees, and
- Certain Retirees

Effective Date: 1-1-20

3.TT-H-830B.101

HSA Plan Options

With the Textron Low Deductible, High Deductible and Maximum Deductible-HSA Plan Options, Covered Health Services expenses are covered at the reimbursement methodologies described in this document, under the Health Coverage component of the Plan. The amounts vary depending upon whether you access care in-network or out-of-network. However, you must meet an annual deductible before the Health Coverage Benefit portion of the Textron Low Deductible, High Deductible and Maximum Deductible-HSA Options begin to pay a percentage of Covered Health Services expenses; and, at any time, reimbursement from your HSA can provide payment for the annual deductible or your portion of coinsurance.

Below is information about the components of the Health Coverage Benefit for the HRA and HSA Plan Options. These components also relate to the Preventive Care Benefit and Out-of-Area (OOA) option of this Plan.

Network

Although you are not required to use a network provider, physicians and other health care providers in the network have agreed to charge lower, negotiated fees for medical services to participants enrolled in the Plan.

The Plan pays a higher percentage of Covered Health Services expenses for network providers and you will generally pay lower out-of-pocket costs when you stay in the network. Once you reach the out-of-pocket maximum for the calendar year, the plan pays 100% of the charges for Covered Health Services expenses. See the ***Textron Medical Plans Detail*** chart for differences in your Network and out-of- network Benefits.

To determine whether your physician or other healthcare provider is in the network, contact your Claims Administrator. The Claims Administrator can provide you a copy of the provider directory, free of charge. You may also obtain provider directories by accessing the Claims Administrator's Website.

Out-of-Network

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense.

The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-network provider about their billed charges before you receive care.

Here's how your out-of-network benefit works:

- The Plan pays a lower percentage of Eligible Expenses, after you meet your annual deductible. (See the ***Textron Medical Plans Detail*** chart for deductible and coinsurance amounts.) However, if your Out-of-Network provider's charges exceed the Eligible Expenses, you pay any excess amount.

- You will pay a higher coinsurance percentage for out-of-network services and generally will pay higher out-of-pocket costs when you visit an Out-of-Network Provider.
- The out-of-network benefit has an unlimited out-of-pocket maximum. You will pay 50% of Eligible Expenses once you meet your out-of-network deductible with no maximum out-of-pocket.
- For reimbursement of out-of-network expenses, you must file your own claims with the Claims Administrator.
- If you require a specific Covered Health Service expense that is not available from a Network provider within 30 miles of your home, the Plan will pay for such covered expense from an out-of-network provider at the in-network provider benefit level (subject to the Deductible and other restrictions) subject to the limitation given below. Requests for this benefit should be made by calling the phone number on the back of your ID card *before* you obtain such services.
- Your selection of an Out-of-Network Provider is limited when you require a specific Covered Health Service expense that is not available from a Network Provider who is located within 30 miles from your home. The Plan will not pay for a Covered Health Service expense from an Out-of-Network Provider at the Network Provider benefit level when you must travel a greater distance to an Out-of-Network provider than to a Network Provider who is available to you at the same or shorter distance.

Eligible Expenses

Textron has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare (i.e., you do not choose to use a non-Network provider), Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When you choose to seek services from a non-Network Provider, the Benefits will be paid at the non-Network 50% coinsurance level, and Eligible Expenses will be determined based on:
 - 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - For Mental Health Services and Substance-Related and Addictive Disorders Services, the Eligible Expense is based on 110% of *CMS* published rates and will be further reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
- When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group.
 - For Pharmaceutical Products, UnitedHealthcare uses methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate is not published by *CMS* for the service and a methodology does not apply to the service, the Eligible Expense is typically based on 20% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

It is recommended that you utilize the services of an in-network provider whenever possible to maximize your healthcare benefits. However, if you require a specific covered service that is not available from an in-network provider, contact UnitedHealthcare at the number on the back of your ID card before you receive the services.

Exhibit 4



2022 Summary Plan Description

This 2022 Summary Plan Description completely replaces any previously issued Summary Plan Description or Your Employee Benefits book (YEB). It is a detailed guide to your FedEx health and welfare benefits.

- Either enter a provider name and search or select the Doctor Type, Name or Reason for Visit Category. The categories allow you to search for a medical professional or behavioral clinician. You can search by provider name, type, location, and facilities (i.e. outpatient) or by reason for visit.
- Once you have your search results, you can reduce the list by using filters (go virtual see a local provider) for distance, specialty type, quality measures, and more.

How to Find a Cigna In-Network Provider (pre-Cigna members)

- Navigate to www.cigna.com
- Click on **Health Care Providers** at the top
- Click on **Find a Provider** at the top
- Click on **Employer or School** icon
- Add zip code
- Click on **Continue as a Guest**
- Select the applicable **Search the provider Network** button based on the plan you are considering:
 - Narrow – LocalPlus (70 HRA, 70 HSA, 80 HRA, 80 HSA)
 - Broad – Open Access Plus with CareLink (70 HRA, 70 HSA, 80 HRA)
 - PPO Out-of-area – PPO

For a list of participating providers in your local area or in another area of the country, you can also call Choose Well Care Connect at **1.833.FDXWELL (339.9355)**.

Out of Network Coverage

The Plan generally does not cover out-of-network services and covers out-of-network services only in limited circumstances, such as services received by Out-of-Area option participants and emergency services.

In some of the limited circumstances where the plan does cover out-of-network services, which are summarized below, the Plan does not cover out-of-network charges above a limit determined by your medical plan administrator for the service, an amount known as the “Maximum Reimbursable Charge.” In these situations, you may be responsible for the amounts the out-of-network provider or facility bills you in excess of the Maximum Reimbursable Charge, a practice called “balance billing,” and the amount above the Maximum Reimbursable Charge will not count towards the deductible or out-of-pocket maximum. In other situations, federal law may prohibit providers from balance billing you and you are only responsible for in-network cost sharing, such as your in-network deductible and coinsurance.

Summary of Limited Out-of-Network Coverage

- *Out-of-Network Emergency Services Subject to Protection from Balance Billing Under Federal Law.* If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility generally may bill you is your medical plan option’s in-network cost-sharing amount (such as deductibles, copayments, and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
- *Other Emergency Services Not Subject to Protection from Balance Billing Under Federal Law.* The Plan will apply in-network cost sharing to eligible out-of-network emergency services billed charges, up to the Maximum Reimbursable Charge, if the Emergency Services are not subject to protection from balance billing under federal law as described above. Emergency Services are defined for the purpose of this Plan as services provided at an emergency room or emergency transportation by an ambulance (air or ground), as well as the treatment you receive at a hospital after being admitted upon receiving emergency room treatment until you can feasibly be transferred to an in-network facility as determined by a case manager assigned by the Medical Plan Administrator. Remember, many emergency services, other than ground ambulance services, will be subject to protections from balance billing as described above.
- *Certain Services at an In-Network Hospital or Ambulatory Surgical Center Subject to Protection from Balance Billing.* When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In such cases where you are not given advanced notice that a provider is out-of-network, the most those providers may bill you is your medical plan option’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed. You may be subject to balance billing, however, if an out-of-network provider providing services at an in-network facility informs you in advance that the provider is out-of-network, provides an estimate of the charges, and secures a

written acknowledgement from you that you received the notice and understand that any cost-sharing applied to the provider's services.

- *Out-of-Network Lab Testing Initiated by and in the Office of an In-Network Provider.* When you see an in-network provider and a specimen for covered laboratory testing is taken from you in the in-network provider's office, but the in-network provider sends the specimen to an out-of-network laboratory for testing, the Plan will apply in-network cost sharing to the charges of that out-of-network laboratory. If Cigna is your Medical Plan Administrator, the Plan will apply in-network cost sharing to the eligible billed charges of the out-of-network laboratory. If UHC is your Medical Plan Administrator, the Plan will apply in-network cost sharing to an eligible billed charge of the out-of-network laboratory up to the Maximum Reimbursable Charge and UHC will initiate negotiations with the laboratory if it does not accept payment at or below the Maximum Reimbursable Charge level as full payment for the service.
- *Pre-Approved Out-of-Network Services Due to Lack of Local In-Network Providers-Gap Exceptions.* With Medical Plan Administrator pre-approval, the Plan will apply in-network cost sharing to the eligible charges, up to the Maximum Reimbursable Charge, of an out-of-network provider that you are authorized to see because you do not live within 25 miles of an in-network provider of that specific type. In these situations, the Medical Plan Administrator generally will attempt to negotiate a rate with the out-of-network provider that is at or below the Maximum Reimbursable Charge.
- *Hearing Aids.* The Plan will apply in-network cost sharing to the cost of hearing aid appliances purchased from an out-of-network provider and repairs provided by an out-of-network provider. Coverage of hearing aid appliances and hearing aid repairs, provided by either in-network or out-of-network providers, is limited to \$5,000 every three years per individual covered the Plan.

Special Rules for the Out-of-Area Option

The Out-of-Area option provides coverage for eligible services rendered by providers and facilities outside of your Medical Plan Administrator's network. Under the Out-of-Area option, however, Maximum Reimbursable Charge limits will apply to benefit payments for the services you receive unless you use a provider that is in-network with your Medical Plan Administrator. The out-of-network provider may be able to bill you for the amount above the Maximum Reimbursable Charge, a practice called "balance billing." You are responsible for charges that exceed the Maximum Reimbursable Charge, not the Plan, unless the Out-of-Network services you receive are subject to protections from balance billing under federal law in which case you will not be responsible for the difference between the amount the Medical Plan Option agrees to pay for the service and the full amount charged for the service, subject to your responsibility for coinsurance, copays, and deductibles. Gap exceptions do not generally apply to the Out-of-Area option since there are no requirements on the use of in-network providers.

While it is not required in the Out-of-Area option to use in-network providers, providers in your Medical Plan Administrator's network accept the Medical Plan Administrator's negotiated rate and agree to bill the Medical Plan Administrator directly for services rendered, less the amount of your cost-sharing responsibility. This means that when you use in-network care under the Out-of-Area option you generally pay less out of your pocket for care, you are not billed for amounts in excess of the negotiated rates, and there are no claim forms to file.

Special Rules for Covered Employees Resident in Alaska and Their Covered Dependents

Alaska-resident covered employees and their covered dependents may use their provider of choice in Alaska, including providers that are not in-network with UHC, the medical plan administrator in Alaska. Covered out-of-network provider services will be reimbursed at the in-network coverage level. The plan, however, will not reimburse charges for a service above Maximum Reimbursable Charge, as determined by UHC. Alaska-resident employees and their covered dependents are not required to call in advance for approval to receive covered out-of-network services but are encouraged to contact UHC about pre-determination before undergoing significant procedures to learn more about potential cost. Members in Alaska still have access to UHC in-network providers and are eligible for discounts and protected from being charged above Maximum Reimbursable when using an in-network provider.

While eligible claims for out-of-network providers in Alaska will be payable by the Plan at the in-network coverage level up to the Maximum Reimbursable Charge, out-of-network providers can bill members for the difference between what they billed for a service and the Plan's Maximum Reimbursable Charge level for that service, a practice called "balance billing." Accordingly, you may owe a substantial sum to an out-of-network provider for a service even after UHC has processed the claim. Participants also do not receive deductible or out-of-pocket maximum credit for amounts balance billed above the Maximum Reimbursable Charge. Gap exceptions do not generally apply since there are no requirements on the use of in-network providers.

Maximum Reimbursable Charge Determination and Application

Maximum Reimbursable Charge limits are not determined by FedEx. These limits are set according to the Medical Plan Administrator's guidelines as described below.

Cigna

For the medical plan options administered by Cigna, Maximum Reimbursable Charge means:

(1) Under the Out-of-Area option and for participants subject to the special Alaska out-of-network coverage rules, the Maximum Reimbursable Charge will be the **90th percentile** of the eligible expenses in the geographic area where the service is received based on information from an independent third-party database. The FAIR Health database is used to determine eligible expenses for professional service claims and the Viant database is used to determine eligible expenses for outpatient facility claims.

(2) In the other limited circumstances out-of-network coverage is available and subject to a Maximum Reimbursable Charge under the 70 Narrow, 70 Broad, 80 Narrow, 80 Broad, Bind, and Tiered options, except for out-of-network emergency services described below in paragraph (3), the Maximum Reimbursable Charge for providers not participating in the Medical Plan Administrator's applicable network is:

- 110% of the Medicare rates in the geographic area determined using Centers for Medicare and Medicaid Services methodology for Medicare rate setting; or
- If a Medicare rate is not available for the service, the fee schedule developed by the Medical Plan Administrator calculated using methodology similar to the one used by Medicare; or
- If the service is not on the Medical Plan Administrator's fee schedule or the schedule of Medicare rates, the lesser of (A) the billed charges, or (B) a percentile of what other doctors or facilities in the area in which the service is performed typically charge for the same service. The charges are based upon information from independent third-party databases. The FAIR Health database is used to determine eligible expenses for professional service claims and the Viant database is used to determine eligible expenses for outpatient facility claims.

(3) With respect to out-of-network emergency services (as described under "*Other Emergency Services Not Subject to Protection from Balance Billing Under Federal Law*" above) under the 70 Narrow, 70 Broad, 80 Narrow, 80 Broad, and Tiered options, Maximum Reimbursable Charge is the lesser of:

- The median amount negotiated with in-network providers for the emergency service (excluding in-network deductibles, copayments, or coinsurance); or
- The Maximum Reimbursable Charge determined using the rules set forth in paragraph (2) above.

The Maximum Reimbursable Charge for emergency services and non-emergency services provided by out-of-network providers at certain participating facilities that are subject to balance billing protections shall be determined in accordance with federal law and the participant generally will not be held responsible for amounts in excess of in-network cost sharing without the participant's consent.

UHG/Bind

UHG and Bind refer to the Maximum Reimbursable Charge as the Allowed Amount. For the medical plan options administered by UHG and Bind, the Allowed Amounts are determined as follows or in accordance with applicable law:

- When covered services are received from an out-of-network provider as arranged by the Medical Plan Administrator Allowed Amounts are an amount negotiated by the Medical Plan Administrator or an amount permitted by law. Contact ChooseWell Care Connect if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

When services eligible for the limited out-of-network coverage under the Plan are received from an out-of-network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain network facilities from out-of-network physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Medical Plan Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Medical Plan Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center as described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and

consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable in-network copayment, coinsurance, or deductible.

- **For Emergency Health Care Services provided by an out-of-network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Medical Plan Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Medical Plan Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable in-network copayment, coinsurance or deductible.

- **For Air Ambulance transportation provided by an out-of-network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Medical Plan Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Medical Plan Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable in-network copayment, coinsurance or deductible.

- **For Emergency ground ambulance transportation provided by an out-of-network provider**, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

Other Out-of-Network Services Covered by the Plan

As noted, FedEx Medical Plan options generally do not cover out-of-network services except as described in this section. In the event a FedEx Medical Plan option administered by UHC or Bind covers services received from an out-of-network provider in a situation not described above in this section, Allowed Amounts are determined as follows: an amount negotiated by the Medical Plan Administrator, a specific amount required by law (when required by law), or an amount the Medical Plan Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-network provider, the applicable coinsurance, copayment or any deductible. The Plan offers to provide advocacy services on your behalf with respect to out-of-network providers that have questions about the Allowed Amounts and how the Medical Plan Administrator determined those amounts. Please contact Choose Well Care Connect if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible to access the advocacy services. Following the conclusion of the advocacy services described below, any responsibility to pay more than the Allowed Amount (which includes your coinsurance, copayment, and deductible) is yours.

UHC, Bind and Cigna update their Maximum Reimbursable Charge tables regularly to keep pace with the constant change in medical costs. Contact Choose Well Care Connect at **1.833.FDXWELL (339.9355)** if you have questions about the Maximum Reimbursable Charge for a specific medical service or supply.

Out-of-Pocket Maximum

Each Medical Plan option has an annual out-of-pocket maximum that protects you financially from high-cost medical expenses. When your share of the cost of eligible medical expenses (your out-of-pocket coinsurance and deductible) reaches the annual out-of-pocket maximum, the plan will pay 100% of your eligible expenses (up to the applicable expense limit), for the rest of the calendar year. The Medical and Mental Health/Substance Use annual out-of-pocket maximum is combined. A separate out-of-pocket maximum applies to pharmacy expenses when enrolled in a HRA Medical Plan option and these accumulations do not cross apply. If enrolled in a HSA Medical Plan option, your medical and pharmacy expenses apply to the same out-of-pocket maximum. All coinsurance and medical copays apply to the applicable out-of-pocket maximum.

Exhibit 5

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan BCWN (Low)

of

Insperity Holdings, Inc.

Group Number: 701648

Effective Date: January 1, 2021

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network provider (other than services otherwise arranged by us), you will be responsible to the out-of-Network provider for any amount billed that is greater than the amount we determine to be an Allowed Amount, except as specified below. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on:
 - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ♦ Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar Durable Medical Equipment, or *CMS* competitive bid rates.
 - ♦ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters*

(published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

For Covered Health Care Services received from an out-of-Network diagnostic imaging provider or laboratory service provider performed in connection with a service performed by a Network provider, the Allowed Amount is based on the usual and customary rate, which is defined as:

- For diagnostic imaging services: 110% of the published rates allowed by *CMS* for the same or similar service within the geographic market.
- For laboratory services: 50% of the published rates allowed by *CMS* for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: When services are performed in connection with a service performed by a Network provider, out-of-Network diagnostic imaging providers or laboratory service providers are not allowed to bill you for any difference between the provider's billed charges and the Allowed Amount described here. However, you should contact us if you receive such a bill and we will work with the provider so that you are only responsible for your Co-payment, Co-insurance and/or deductible.

For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician, the Allowed Amount is based on the usual and customary rate, which is defined as the median amount negotiated with Network providers for the same service.

IMPORTANT NOTICE: Out-of-Network facility based Physicians are not allowed to bill you for any difference between the Physician's billed charges and the Allowed Amount described here; however, you should contact us if you receive such a bill and we will work with the provider so that you are only responsible for your Co-payment, Co-insurance and/or deductible.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

- The usual and customary rate, which is defined as the median amount negotiated with Network providers for the same service.

- The amount that would be paid under Medicare (*part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.*) for the same service.

When a rate is not published by CMS for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: Out-of-Network providers are not allowed to bill you for any difference between the provider's billed charges and the Allowed Amount described here; however, you should contact us if you receive such a bill and we will work with the provider so that you are only responsible for your cost share amount.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Exhibit 6

Summary Plan Description

Love's Travel Stops and Country Stores, Inc. Employee Health Care Medical Plan B

Effective: January 1, 2021
Group Number: 905754



SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Love's Travel Stops and Country Stores, Inc. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Provider If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is

outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

Love's Travel Stops and Country Stores, Inc. has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts applies based on claim type:
 - ◆ Eligible Expenses are determined based on 140% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

- ◆ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 140% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card

Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Exhibit 7

**Southwest Airlines Co. Welfare Benefit Plan
Summary Plan Description
Effective January 1, 2019**

Person as required by a state plan for medical assistance approved under Title XIX, §1912(a)(1)(A) of the Social Security Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993); but state law does not apply it attempts to create rights for the state plan that are greater than those of the Covered Person under the Plan. Nevertheless, the fact that an individual is eligible for or is provided medical assistance under the state plan will not be taken into account in determining that individual's eligibility to participate in the Medical Program or Dental Program or the amount of benefits available under the Medical Program or Dental Program.

ALLOWABLE AMOUNT—GENERAL INFORMATION: The Medical Program and the Dental Program cover only charges that the Claims Administrator determines to be Eligible Charges/Covered Charges and that do not exceed the amount usually charged by most Providers in the same geographic area for services, treatment, materials, or supplies. If the charges are subject to contractual discount arrangements as negotiated by the Plan and In-Network Providers (or some other passive network Provider arrangement), then the Plan will pay at the contracted rate.

- If there are no Providers of comparable services or supplies in the same locality, or if there is an unusual type of service or supply, the Claims Administrator will determine the Allowable Amount based on: the complexity involved; the degree of professional skill required; the cost of the services or supplies; and any other pertinent factors.
- Payment of flat rate charges may be declined when procedures, fees, or time involved are not itemized.

FILING A CLAIM FOR BENEFITS AND PAYMENT FOR SERVICES: You must submit a Claim Form to the Claims Administrator to request payment of benefits. **Do not send Your Claim Form to Southwest.** If You send Your Claim Form to Southwest, Your claim will not be processed. Claim Forms are available by calling the Claims Administrator or by logging into the Claims Administrator's website. Some Providers may file claims for You. You should still obtain an itemized statement from Your Provider for Your records. Even if Your Provider files Your claim for You, You may be required to complete a Claim Form before the Claims Administrator can process the claim.

- If You provide written authorization to allow direct payment to a Provider, all or a portion of any Eligible Charges/Covered Charges due to a Provider may be paid directly to the Provider instead of being paid to You. The Claims Administrator will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

EXPLANATION OF BENEFITS (EOB): When a Provider processes at least one claim for You or a Covered Family Member, You will receive an EOB that provides detailed information about Your claims. You may also track claims online.

Medical Program	www.myuhc.com
Dental Program	www.deltadental.com/southwest
Vision Program	www.eyemedvisioncare.com/swa

CLAIMS ADMINISTRATOR REVIEW OF CLAIMS: After receipt of a Claim Form, the Claims Administrator will review the claim to determine if the claim is covered under the Plan. The Claims Administrator will notify You if additional information is needed to process the claim. The Claims Administrator may hold Your claim in processing until all required information is received.

To determine the benefits payable under the Plan, diagnostic aids such as preoperative x-rays and other support documentation may be required. If these aids are not made available, then You may receive no benefit from the Plan or a lesser benefit than the Plan would have paid if the required information had been provided. If a question arises concerning the basis of a claim or a claim payment, the Covered Person may be required to be examined, at the expense of the Plan Administrator, as often as necessary to resolve the issue.

PAYMENT OF APPROVED CLAIMS: If all or part of Your claim is approved, then Your claim will be paid to the extent benefits are payable.

- If a Covered Person receives Covered Health Services from an In-Network Provider, You are responsible for paying the Deductible and any Copayment/Coinsurance to the In-Network Provider at the time of service or when You receive a bill from the In-Network Provider. For amounts that exceed Your Deductible and Copayment/Coinsurance, In-Network Providers are paid directly for Covered Health Services by the Plan. If an In-Network Provider bills You for any

Covered Health Service in excess of Your Deductible or Copayment/Coinsurance, contact the Claims Administrator immediately. If the Claims Administrator cannot resolve the issue to Your satisfaction over the phone, then You may submit Your question in writing to the Claims Administrator.

- If a Covered Person receives Covered Health Services from an Out-of-Network Provider, then You are responsible for payment at the time of service and responsible for requesting reimbursement through the Claims Administrator, unless the Out-of-Network Provider is willing to file the claim for You. You or the Out-of-Network Provider must file the claim in a format that contains all of the information required as described below. You should file claims for Eligible Charges as soon as reasonably possible and in no event later than one Year after the date of service. If You don't file a claim or provide the required information to the Claims Administrator within this timeframe, then benefits for that Covered Charge will be denied. If the claim relates to an inpatient stay, then the date of service is the date the inpatient stay ends.
- If You receive services or supplies from an In-Network Provider, You will be responsible for the Deductible and Copayment/Coinsurance, and all other payments will go directly to Your Provider. In all other cases (for example, if You receive services or supplies from an Out-of-Network Provider), You will be reimbursed for amounts You paid at the time of service (after Your request for reimbursement) unless the Provider is willing to file the claim for You. If the Provider notifies the Claims Administrator that Your signature is on file allowing the Provider to file claims on your behalf or You make a written request that the Provider be paid directly at the time You submit Your claim, Your Provider will be reimbursed (except for any Deductible or Copayment/Coinsurance) to the extent that benefits are payable. Upon making this payment, Southwest, the Plan Administrator, the Claims Administrator, and the Plan is released from any further obligation for the claim payment.
- The Deductible (if any) may be withheld from any Eligible Charges and divided among You and any assignees. This claims payment method is legally binding.

DENIAL OF CLAIMS: If all or part of the claim is denied, You will receive written notice from the Claims Administrator which will explain the reason for denial and provide the claim appeal procedures. If You filed the claim improperly or if additional information is needed to process the claim, the notice will describe how to correct the claim or provide the additional information needed. For additional information on appeal procedures, see the section of this SPD that addresses filing appeals.

- Note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between the Covered Person and his or her Physician; but, note, a health service may or may not be a covered benefit regardless of whether a Physician or the Covered Person determines that it is needed.
- The Claims Administrators have the exclusive right to interpret and administer the Plan, and the Claims Administrators' decisions are conclusive and binding.

Return of Overpayment of Claims: Payment made for charges must be returned to the Plan if it is found that such charges were paid in error. Any unrecovered overpayments will be deducted from any future assigned or unassigned benefits You or Your Family Member would be eligible to receive under the Plan making the overpayment or any other Southwest plan. Furthermore, if a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency who receives or holds such benefit. Such excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding such excess amounts must produce any instruments or papers necessary to ensure this right of recovery.

DEADLINE FOR FILING A LAWSUIT/LIMITATION OF ACTIONS: You cannot bring any legal action against Southwest or the Claims Administrator for any other benefit claim or reason unless You first complete all the steps in the claims procedure process described in this SPD. After completing that process, if You want to bring a legal action against Southwest or the Claims Administrator, You must do so within three Years of the deadline to submit Your initial claim (as described at the end of Section 1 under "Claims Procedures and Appeals"); otherwise You lose any rights to bring such an action against Southwest or the Claims Administrator (except to the extent the provisions of any benefit Program provide for a different time frame).

MANDATORY VENUE: Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to this Plan, must be brought in federal court in Dallas County, Texas. The federal courts in Dallas County, Texas have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

DISABLED: For purposes of the LTD Program, the Employee is considered Disabled if, solely because of Injury or Sickness, the Employee is (i) unable to perform the Material Duties of his or her Own Occupation and (ii) unable to earn 80% or more of his or her Indexed Earnings from working in his or her Own Occupation. After Disability Benefits have been payable for 24 Months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is (i) unable to perform the Material Duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience and (ii) unable to earn 60% or more of his or her Indexed Earnings for BenefitsPlus or 50% or more of his or her Indexed Earnings for the Regular Plan. The Insurance Carrier will require proof of earnings and continued disability.

DISABILITY EARNINGS

For purposes of the Short Term Disability Program, any wage or salary for any work performed for Southwest Airlines during Your Disability. It does not include commissions, bonus, overtime pay or other extra compensation.

DURABLE MEDICAL EQUIPMENT: Durable Medical Equipment means equipment that meets all of the following: (i) it is for repeated use and is not a consumable or disposable item; (ii) it is used primarily for a medical purpose; and (iii) it is appropriate for use in the home.

ELIGIBLE CHARGES: Eligible Charges are different for In-Network Providers and Out-of-Network Providers. In addition, for certain Covered Health Services, You are required to pay a percentage of Eligible Charges in the form of a Copayment or Coinsurance. Eligible Charges are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to Your claim from the Claims Administrator.

- Eligible Charges for Covered Health Services received from In-Network Providers are the contracted fee(s) with that Provider.
- When Covered Health Services are received from an Out-of-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law.
 - (i) For an Emergency, Eligible Charges are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.
 - (ii) 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
 - (iii) When a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service.
- **For services other than Pharmaceutical Products**, the Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. The Claims Administrator and OptumInsight are related companies through common ownership by UnitedHealth Group.
- **For Pharmaceutical Products**, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource.
 - (iv) When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Charge is based on 50% of the provider's billed charge, but certain Eligible Charges for mental health and Substance Use Disorder services are based on 80 % of the billed charge.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

ELIGIBLE DEPENDENT CARE CHARGES: Charges for child or elder care for a dependent that is eligible for reimbursement by the Dependent Care FSA.

Exhibit 8

Summary Plan Description

Dollar Tree Management, Inc. Bronze Plan

Effective: January 1, 2019
Group Number: 752495

Amended: June 1, 2019



SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Dollar Tree Management, Inc. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Dollar Tree Management, Inc. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. Non-Network providers are not contractually limited as to how much they can charge for their services and can balance bill you for any amounts above the Eligible Expense amounts covered by your Plan. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, UnitedHealthcare uses a

gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Exhibit 9

Summary Plan Description and Benefit Programs



MEDICAL PLAN

UnitedHealthcare Option 1 Passive PPO Plan

The Option 1 Passive PPO Plan has a limited nationwide network of doctors, facilities and specialists. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which bases its reimbursement on reasonable and customary charges and pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether or not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility.

- You will receive the same network level of benefits whether you choose a provider in the Choice Plus Network or outside of the network. However, when you receive care from providers who are not part of the UnitedHealthcare network, you do not have the advantage of the UnitedHealthcare network's negotiated rates.
- Preventive care, such as well-baby and well-child checkups, immunizations, and routine physicals for adults and children are covered at 100% whether a network provider is used or not.
- You are encouraged to use network providers when available, in order to receive maximum benefits under the plan. A list of Choice Plus network providers in the UHC Plans is available by calling UnitedHealthcare Member Services at 888-899-4734 or online at www.uhc.com.

How UnitedHealthcare Medical Plans Work

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits. You are responsible for determining whether or not your providers participate in UnitedHealthcare's network so that you are maximizing your benefits under the Medical Plan.

Network Benefits

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

When you use Network providers:

- You will pay UnitedHealthcare's negotiated rates for inpatient and outpatient network services until you reach your annual deductible. The annual deductible varies depending on the plan in which you are enrolled.
- Once you have met your annual deductible, the plan will pay 80% of network claims and you pay the remaining 20% of all covered claims. You continue to pay 20% of all covered claims until you reach your annual out-of-pocket maximum for the calendar year.
- After you meet your out-of-pocket maximum, the plan pays 100% of covered eligible expenses for the remainder of the calendar year.

Network providers are independent practitioners and are not employees of Ryder or UnitedHealthcare. It is your responsibility to select your provider.

MEDICAL PLAN

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Non-Network Benefits

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

When you use Non-Network providers:

- You will pay 100% of your expenses until you reach the annual deductible (including preventive care). When you receive care from providers who are not part of the UnitedHealthcare Choice Plus network, you pay a higher deductible and you do not have the advantage of the UnitedHealthcare network's negotiated rates.
- After the annual deductible is met, for Option 1 and HSA the plan pays benefits up to 60% of Eligible Expenses Payable by the Plan (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, "What the UnitedHealthcare Medical Plans Cover").
- For the Standard Plan the plan pays nothing and you will be responsible for the entire claim.

Note: Services by non-network providers under the Option 1 Passive PPO Plan is covered on a different basis than the Choice Plus Options. The Option 1 Passive PPO Plan is the only plan where you are able to use non-network providers and pay the same deductible and coinsurance as if using a network provider. However, when you receive care from Non-Network providers, you do not have the advantage of UnitedHealthcare's negotiated rates. This plan is only available to employees that live in an area where the number of UnitedHealthcare network providers is limited. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program at the end of the Medical Section of the SPD.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

If You Are Looking for a Network Provider

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

MEDICAL PLAN

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com. Network providers are independent practitioners and are not employees of Ryder or UnitedHealthcare.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid at the non-Network level.

Eligible Expenses (applicable to the UHC Option 1, UHC HSA, UHC Standard Plans)

Ryder has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits (except the Standard Plan), Eligible Expenses are based on when Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion. If rates have not been negotiated:

- Eligible Expenses are determined based on 110 % of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of 50% of CMS for the same or similar laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
- When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and

MEDICAL PLAN

resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance-Related and Addictive Disorder services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card

Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Eligible Expenses (applicable to the Option 1 Passive PPO Plan)

Ryder has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion. If rates have not been negotiated, then Eligible Expenses are

MEDICAL PLAN

determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception 50% of CMS for the same or similar laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

- When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Annual Maximum

There is no annual maximum for Essential Benefits under the Ryder System, Inc. United Healthcare. Essential Health Benefits are health-related items and services that fall into the following categories, as defined in §1302 of health care reform law, and further determined by the Secretary of Health and Human Services: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under health care reform law, the Medical Plans have chosen the State of Florida as its benchmark state.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There is a combined Annual Deductible for Network and Non-Network Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

MEDICAL PLAN

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you participate in UnitedHealthcare Option 1 Medical Plan and that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There is a combined Out-of-Pocket Maximum for Network Benefits and Non-Network Benefits. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided under your outpatient prescription drug plan.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization from UnitedHealthcare when required. Generally, if authorization from UnitedHealthcare is not obtained when required, Benefits will be reduced by 20% of Eligible Expenses.	No	No
Charges that exceed Eligible Expenses	No	No

Important Note: If Prior Authorization is not received, your benefits may be reduced by 20%. In such cases, any expense not paid by the plan will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Exhibit 10

(Filed Under Seal)

Exhibit 11

(Filed Under Seal)

Exhibit 12

(Filed Under Seal)

Exhibit 13

(Filed Under Seal)

Exhibit 14

(Filed Under Seal)

Exhibit 15

(Filed Under Seal)

Exhibit 16

(Filed Under Seal)

Exhibit 17

HEALTH CARE FINANCIAL SERVICES
OF **TEAMHealth**.

265 Brookview Centre Way, Suite 400 • Knoxville, TN 37919
p 800.342.2898 • 865.693.1000
www.hcfln.com

July 2, 2019

United Healthcare Services, Inc.
PO Box 740800
Atlanta, GA 30374-0800

RE: Provider Dispute Reconsideration/Appeal for the Physician Practices noted in Exhibit A (the "Physician Practices").

Dear Appeals Director:

On behalf of the Physician Practices list below, please consider this letter a provider dispute reconsideration/appeal regarding the accounts identified on Exhibit 1 (the "Disputed Claims").

Corp	TIN
ACS Primary Care Physicians of LA, PC	62-1859672
Buffalo Emergency Associates, LLP	16-1581332
Chase Dennis Emergency Medical Group, Inc.	94-3259637
Emergency Associates of Central TX, PA	83-1661941
Emergency Care Services of NY, PC	20-8013577
Emergency Department Physicians, PC	20-0602538
Emergency Group of AZ Professional Corp	46-1813341
Emergency Medical Services of Maine, LLC	83-2446583
Emergency Physician Associates of Indiana, PC	83-3383229
Emergency Physicians of Mid-America, PC	47-1022656
Emergency Professional Services, Inc.	94-2460636
Emergency Professionals of Michigan, PC	46-2593177
Emergency Services of Iowa, LLC	83-3241858
Emergency Services of Kansas, PA	45-2914664
Emergency Services of Montgomery, PC	46-1120780
Emergency Services of Oklahoma, PC	27-2409240
Exigence Medical of Binghamton, PLLC	20-4100362
Exigence Medical of Jamestown, PLLC	45-4286516
Fremont Emergency Services Mandavla, LTD	88-0262438
Hill Country Emergency Medical Associates, PA	47-2775570

FESM000001

UHC0011188

Iowa Emergency Services, LLC	82-4613012
Longhorn Emerg Med Assoc, PA	47-2785231
Longhorn Observation Medical Associates, PA	82-0665511
MEA Chicago, PC	82-1906629
Mercy Emergency Care Services, Inc.	47-2044374
New Hampshire Emerg Phys Assoc, PC	82-4376127
Northwest Emergency Physicians, LLC	91-1753075
Observation Emergency Physicians, PC	26-2505001
Ohio Emergency Care Services, Inc.	47-2051272
Ohio Emergency Professionals, Inc.	45-2962033
Oklahoma Emergency Services, PC	27-2449807
Ruby Crest Emergency Medicine	88-0307849
Sierra ER Department Phys Med Group, Inc	81-1630866
Solano Gateway Medical Group, Inc.	75-2979118
South Central Emergency Services, PC	27-3969969
Southwest Emergency Medicine Associates of NM, PC	82-2541182
Team Physicians of California Medical Group Inc.	94-3302301
Team Physicians of Nevada Mandavia, PC	46-4004517
Team Physicians of Northern CA Med Grp, Inc.	46-4467849
Team Physicians of Southern California Medical Group Inc.	81-1641281

As you know, the Physician Practices does not have a Participating Provider Agreement with United Healthcare Insurance Company (“United”). Accordingly, the Physician Practices has not agreed to accept discounted rates from United or to be bound by United’s unilaterally imposed reimbursement policies or rate schedules with respect to the medical services the Physician Practices provides to your members.

Notwithstanding the absence of a Participating Provider Agreement, the Physician Practices provided medically necessary emergency services and care to your members, as required and appropriate. The Physician Practices timely and appropriately submitted bills to United for payment for the services provided. The Physician Practices’s expected reimbursement is \$4,590,537, which are the Physician Practices’s usual and customary charges for the services rendered to these members.

Unfortunately, United has not adjudicated the Disputed Claims appropriately. As set forth in the claim forms submitted to United, as well as on Exhibit 1, the Physician Practices’ expected total reimbursement on the Disputed Claims is \$4,590,537. Instead, United has underpaid the Disputed Claims by unilaterally imposing purported “allowed amounts” substantially less than the amounts owed on the Disputed Claims. The total purported amount “allowed” on the Disputed Claims by United is, in aggregate, \$1,805,904. The amount due and owing on these accounts is therefore \$2,784,633.

By this letter, the Physician Practices demands that United reprocess the Disputed Claims and remit payment in full on the amount due. We expect that you will remit proper payment within ten (10) business days. In addition, please update all pertinent claims processing system(s) to ensure proper adjudication of future claims in accordance with the Physician Practices's charges.

Should you fail or refuse to remit payment in the full amount that is due and owing on the Disputed Claims, please provide:

1. A detailed explanation of your reasons for failing to do so and of your alternative calculation of the allowed amounts on each Disputed Claim, including the legal and factual bases therefor; and
2. Any information, data, documentation, resource, database, algorithm, guideline, guidance, benchmark, reference, rubric, formula, metric, or other source of data or information (to include, without limitation, any claim adjudication information from third parties, including Data iSight or otherwise) which you in any way have relied upon or utilized in the course of your determination of the amount due and owing on the Disputed Claims.

Please note that, as a non-participating provider, the Physician Practices is under no obligation to utilize United's internal appeals or dispute resolution procedures as a condition precedent to receiving formal legal redress of United's payment deficiencies on the Disputed Claims. Nevertheless, this letter is being sent in a good faith attempt to resolve the Disputed Claims. This letter is written without waiver of any of the Physician Practices's rights and remedies at law and in equity, all of which are expressly reserved.

We appreciate your prompt attention to this matter.

Sincerely,

Kent Bristow
SVP, TeamHealth

HEALTH CARE FINANCIAL SERVICES
OF **TEAM**Health.

265 Brookview Centre Way, Suite 400 • Knoxville, TN 37919
p 800.342.2898 • 865.693.1000
www.hcfin.com

July 2, 2019

United Healthcare Insurance Company
PO Box 30555
Salt Lake City, UT 84130-0555

RE: Provider Dispute Reconsideration/Appeal for the Physician Practices noted in Exhibit A
(the "Physician Practices").

Dear Appeals Director:

On behalf of the Physician Practices list below, please consider this letter a provider dispute reconsideration/appeal regarding the accounts identified on Exhibit 1 (the "Disputed Claims").

Corp	TIN
ACS Primary Care Physicians of LA, PC	62-1859672
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Emergency Services of Kansas, PA	45-2914664
Emergency Services of Montgomery, PC	46-1120780
Emergency Services of Oklahoma, PC	27-2409240
Exigence Medical of Jamestown, PLLC	45-4286516
Fremont Emergency Services Mandavia, LTD	88-0262438
Hill Country Emergency Medical Associates, PA	47-2775570
Longhorn Emerg Med Assoc, PA	47-2785231
Longhorn Observation Medical Associates, PA	82-0665511

FESM000005

UHC0011191

MEA Chicago, PC	82-1906629
Northwest Emergency Physicians, LLC	91-1753075
Northwest Observation Associates, PC	82-1767201
Observation Emergency Physicians, PC	26-2505001
Ohio Emergency Professionals, Inc.	45-2962033
Oklahoma Emergency Services, PC	27-2449807
Premier Emergency Care Services, Inc.	47-2051354
Ruby Crest Emergency Medicine	88-0307849
Sierra ER Department Phys Med Group, Inc	81-1630866
Solano Gateway Medical Group, Inc.	75-2979118
South Central Emergency Services, PC	27-3969969
Southwest Emergency Medicine Associates of NM, PC	82-2541182
Team Physicians of California Medical Group Inc.	94-3302301
Team Physicians of Nevada Mandavia, PC	46-4004517
Team Physicians of Northern CA Med Grp, Inc.	46-4467849
Team Physicians of Southern California Medical Group Inc.	81-1641281

As you know, the Physician Practices does not have a Participating Provider Agreement with United HealthCare Insurance Company ("United"). Accordingly, the Physician Practices has not agreed to accept discounted rates from United or to be bound by United's unilaterally imposed reimbursement policies or rate schedules with respect to the medical services the Physician Practices provides to your members.

Notwithstanding the absence of a Participating Provider Agreement, the Physician Practices provided medically necessary emergency services and care to your members, as required and appropriate. The Physician Practices timely and appropriately submitted bills to United for payment for the services provided. The Physician Practices' expected reimbursement is \$5,922,389, which are the Physician Practices' usual and customary charges for the services rendered to these members.

Unfortunately, United has not adjudicated the Disputed Claims appropriately. As set forth in the claim forms submitted to United, as well as on Exhibit 1, the Physician Practices' expected total reimbursement on the Disputed Claims is \$5,922,389. Instead, United has underpaid the Disputed Claims by unilaterally imposing purported "allowed amounts" substantially less than the amounts owed on the Disputed Claims. The total purported amount "allowed" on the Disputed Claims by United is, in aggregate, \$2,282,083. The amount due and owing on these accounts is therefore \$3,640,306.

By this letter, the Physician Practices demands that United reprocess the Disputed Claims and remit payment in full on the amount due. We expect that you will remit proper payment within ten (10) business days. In addition, please update all pertinent claims processing system(s) to ensure proper adjudication of future claims in accordance with the Physician Practices' charges.

Should you fail or refuse to remit payment in the full amount that is due and owing on the Disputed Claims, please provide: A detailed explanation of your reasons for failing to do so and of your alternative calculation of the allowed amounts on each Disputed Claim, including the legal and factual bases therefor; and

1. Any information, data, documentation, resource, database, algorithm, guideline, guidance, benchmark, reference, rubric, formula, metric, or other source of data or information (to include, without limitation, any claim adjudication information from third parties, including Data iSight or otherwise) which you in any way have relied upon or utilized in the course of your determination of the amount due and owing on the Disputed Claims.

Please note that, as a non-participating provider, the Physician Practices is under no obligation to utilize United's internal appeals or dispute resolution procedures as a condition precedent to receiving formal legal redress of United's payment deficiencies on the Disputed Claims. Nevertheless, this letter is being sent in a good faith attempt to resolve the Disputed Claims. This letter is written without waiver of any of the Physician Practices's rights and remedies at law and in equity, all of which are expressly reserved.

We appreciate your prompt attention to this matter.

Sincerely,

Kent Bristow
SVP, TeamHealth

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,
INC.; UNITEDHEALTHCARE
INSURANCE COMPANY; AND UMR,
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES
SOUTHEAST, P.C.; INPHYNET
PRIMARY CARE PHYSICIANS
SOUTHEAST, P.C.; AND REDMOND
ANESTHESIA & PAIN TREATMENT,
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

**DECLARATION OF WILLIAM D. POLLAK, ESQ. IN
SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I, William D. Pollak, declare and state as follows:

1. I am an attorney with O'Melveny & Myers LLP, counsel to Plaintiffs United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. (collectively, "United"). I submit this Declaration in support of United's Motion for Summary Judgment. I have personal knowledge of the following facts and, if called and sworn as a witness, could and would testify completely thereto.

2. Attached hereto as Exhibit 18 is a compilation of true and correct copies of Business Search results of the Georgia Secretary of State's Corporations Division for Hospital Physician Services Southeast, P.C., Redmond Anesthesia & Pain Treatment, P.C., and InPhyNet Primary Care Physicians Southeast, P.C., bearing Bates stamps UHC0012111, UHC0012125, and UHC0012126.

3. Attached hereto as Exhibit 19 is a true and correct copy of excerpts from the deposition of Kent Bristow, taken on April 12, 2023 in *Emergency Physician Services of New York v. UnitedHealth Group, Inc.*, 1:20-CV-01983-JGK-SN, in the United States District Court for the Southern District of New York, bearing Bates stamps UHC0012099 through UHC0012102.

4. Attached hereto as Exhibit 20 is a true and correct copy of excerpts from the 30(b)(6) deposition of Kent Bristow, taken on June 29, 2022 in *Gulf-to-Bay Anesthesiology Associates, Inc. v. UnitedHealthcare of Florida, Inc.*, No. 2017-CA-011207, in the Circuit Court for the Thirteenth Judicial Circuit in Hillsborough County, Florida, bearing Bates stamps UHC0012107 through UHC0012110.

5. Attached hereto as Exhibit 21 is a true and correct copy of excerpts from the 30(b)(6) deposition of Kent Bristow, taken on May 13, 2021 in *Fremont Emergency Services (Mandavia) Ltd. v. UnitedHealth Group*, No. A-19-792978-B

in the District Court of Clark County, Nevada, bearing Bates stamps UHC0012103 through UHC0012106.

6. Attached hereto as Exhibit 22 is a true and correct copy of excerpts from the deposition of Paul Bevilacqua, taken on March 17, 2023 in *Emergency Physician Services of New York v. UnitedHealth Group, Inc.*, 1:20-CV-01983-JGK-SN, in the United States District Court for the Southern District of New York, bearing Bates stamps UHC0012092 through UHC0012098.

7. Attached hereto as Exhibit 23 is a true and correct copy of an April 18, 2019 email sent by Leif Murphy to Mike Wiechart, David Jones, Joe Carman, Kent Bristow, Carol Owen, Lynn Massingale, and Phil McSween, and attachment, bearing Bates stamps UHC0004779 through UHC0004782. Exhibit 23 was authenticated and admitted as Exhibit 4918, bearing Bates stamp FESM008944, at page 116 of the November 16, 2021 transcript of day 13 of the trial in *Fremont Emergency Services (Mandavis) Ltd. v. United Healthcare Insurance Co.*, No. A-19-792978-B in the District Court of Clark County, Nevada, attached hereto as Exhibit 25 to the Declaration of William Pollak ("Pollak Declaration"). A similar version of Exhibit 23 was authenticated and admitted into evidence as Defendants Trial Exhibit 368 at page 87 of the April 17, 2024 transcript of day 11 of the trial in *Emergency Services of Oklahoma v. United Healthcare Insurance Co.*, No. CJ-2019-482 in the District Court of Cleveland County in Oklahoma (attached hereto

as Exhibit 24 to the Pollak Declaration). As of April 18, 2019 meeting, TeamHealth had already initiated 4 lawsuits against United across the country.

8. Attached hereto as Exhibit 24 is a true and correct copy of pages 75–76, 83–84, 87–90 and 93–95 from the April 17, 2024 transcript of day 11 of the trial in *Emergency Services of Oklahoma v. United Healthcare Insurance Co.*, No. CJ-2019-482 in the District Court of Cleveland County in Oklahoma, bearing Bates stamps UHC0012112 through UHC0012124.

9. Attached hereto as Exhibit 25 is a true and correct copy of excerpts of the November 16, 2021 transcript of day 13 of the trial in *Fremont Emergency Services (Mandavis) Ltd. v. United Healthcare Insurance Co.*, No. A-19-792978-B in the District Court of Clark County, Nevada, bearing Bates stamps UHC0012129 through UHC0012132.

10. Attached hereto as Exhibit 26 is a true and correct copy of *Atlantic ER Physicians Team Pediatric Associates, PA v. UnitedHealth Grp., Inc.*, No. 1:20-cv-20083, ECF No. 2 (D.N.J. Dec. 21, 2020).

11. Attached hereto as Exhibit 27 is a true and correct copy of *Florida Emergency Physicians Kang & Associates, M.D., Inc. v. United Healthcare of Florida, Inc.*, No. 0:20-cv-60757, ECF No. 27 (S.D. Fla. June 9, 2020).

12. Attached hereto as Exhibit 28 is a true and correct copy of the First Amended Complaint filed in *Emergency Group of Arizona Professional Corp.*

v. United Healthcare Inc., No. 2:19-cv-04687, ECF No. 18 (D. Ariz. Aug. 9, 2019).

13. Attached hereto as Exhibit 29 is a true and correct copy of a letter dated January 23, 2024 from United's Counsel Greg Jacob of O'Melveny & Myers, LLP to Kent Bristow of TeamHealth Holdings, Inc. and Plaintiffs' Counsel James Cobb and Cameron Roberts of Caplan Cobb LLC.

14. Attached hereto as Exhibit 30 is a true and correct copy of a letter dated January 29, 2024 from Plaintiffs' Counsel Justin Fineberg of Lash Goldberg to United's Counsel Greg Jacob of O'Melveny & Myers, LLP.

I declare under penalty of perjury that the foregoing is true and correct.

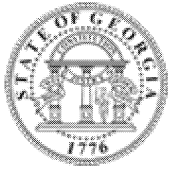
Executed this 11th day of April, 2025 in New York, New York.



/s/

William D. Pollak

Exhibit 18



GEORGIA CORPORATIONS DIVISION

GEORGIA SECRETARY OF STATE
BRAD RAFFENSPERGER

[HOME \(/\)](#)

BUSINESS SEARCH

BUSINESS INFORMATION

Business Name: **HOSPITAL PHYSICIAN
SERVICES-SOUTHEAST,
PROFESSIONAL
CORPORATION** Control Number: **0570133**

Business Type: **Foreign Profit
Corporation** Business Status: **Active/Compliance**

Business Purpose: **NONE**

Principal Office Address: **265 Brookview Centre
Way Ste 203, Attn Legal
Dept, KNOXVILLE, TN,
37919, USA** Date of Formation /
Registration Date: **10/21/2005**

Jurisdiction: **Louisiana** Last Annual Registration
Year: **2027**

REGISTERED AGENT INFORMATION

Registered Agent Name: **Corporation Service Company**

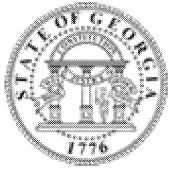
Physical Address: **2 SUN COURT, SUITE 400, PEACHTREE CORNERS, GA, 30092, USA**

County: **Gwinnett**

OFFICER INFORMATION

Name	Title	Business Address
Alice Leone	CFO	265 Brookview Centre Way, Suite 203, Knoxville, TN, 37919, USA
John R. Stair	Secretary	265 Brookview Centre Way, Suite 203, KNOXVILLE, TN, 37919, USA
Joseph T Crane	CEO	265 Brookview Centre Way, Suite 203, KNOXVILLE, TN, 37919, USA

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GEORGIA CORPORATIONS DIVISION

GEORGIA SECRETARY OF STATE
BRAD RAFFENSPERGER

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BUSINESS SEARCH

BUSINESS INFORMATION

REDMOND
Business Name: **ANESTHESIA & PAIN TREATMENT, P.C.** Control Number: **12039510**
Business Type: **Domestic Professional Corporation** Business Status: **Active/Compliance**
Business Purpose: **NONE**
Principal Office Address: **265 Brookview Centre Way Ste 203, Knoxville, TN, 37919, USA** Date of Formation / Registration Date: **5/7/2012**
State of Formation: **Georgia** Last Annual Registration Year: **2027**

REGISTERED AGENT INFORMATION

Registered Agent Name: **Corporation Service Company**
Physical Address: **2 SUN COURT, SUITE 400, PEACHTREE CORNERS, GA, 30092, USA**
County: **Gwinnett**

OFFICER INFORMATION

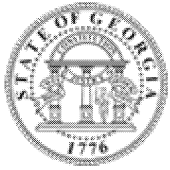
Name	Title	Business Address
Alice Leone	CFO	265 Brookview Centre Way Ste 203, Knoxville, TN, 37919, USA
John R. Stair	Secretary	265 Brookview Centre Way, Suite 203, Knoxville, TN, 37919, USA
Randal Dabbs, MD	CEO	265 Brookview Centre Way Ste 203, Knoxville, TN, 37919, USA

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Office of the Georgia Secretary of State Attn: 2 MLK, Jr. Dr. Suite 313, Floyd West Tower Atlanta, GA 30334-1530,
Phone: (404) 656-2817 Toll-free: (844) 753-7825, WEBSITE: <https://sos.ga.gov/>

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GEORGIA CORPORATIONS DIVISION

GEORGIA SECRETARY OF STATE
BRAD RAFFENSPERGER

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BUSINESS SEARCH

BUSINESS INFORMATION

**INPHYNET PRIMARY
CARE PHYSICIANS-
SOUTHEAST,
PROFESSIONAL
CORPORATION**

Business Name: **SOUTHEAST,
PROFESSIONAL
CORPORATION** Control Number: **K410835**

Business Type: **Foreign Profit
Corporation** Business Status: **Active/Compliance**

Business Purpose: **NONE**

Principal Office Address: **1643 NW 136TH AVE,
BUILDING H, SUITE 100,
Sunrise, FL, 33323, USA** Date of Formation /
Registration Date: **4/28/1994**

Jurisdiction: **Louisiana** Last Annual Registration
Year: **2027**

REGISTERED AGENT INFORMATION

Registered Agent Name: **Corporation Service Company**

Physical Address: **2 SUN COURT, SUITE 400, PEACHTREE CORNERS, GA, 30092, USA**

County: **Gwinnett**

OFFICER INFORMATION

Name	Title	Business Address
Alice Leone	CFO	265 Brookview Centre Way Ste 203, Knoxville, TN, 37919, USA
John R Stair	Secretary	265 Brookview Centre Way, Suite 203, Knoxville, TN, 37919, USA
Joseph T Crane	CEO	265 Brookview Centre Way, Suite 203, Knoxville, TN, 37919, USA

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Office of the Georgia Secretary of State Attn: 2 MLK, Jr. Dr. Suite 313, Floyd West Tower Atlanta, GA 30334-1530,
Phone: (404) 656-2817 Toll-free: (844) 753-7825, WEBSITE: <https://sos.ga.gov/>

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Exhibit 19

KENT BRISTOW
EMERGENCY PHYSICIAN vs UNITEDHEALTH

April 12, 2023

1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK
CASE NO. 1:20-CV-01983-JGK-SN

EMERGENCY PHYSICIAN SERVICES OF NEW YORK, et al.,
Plaintiffs,
vs.
UNITEDHEALTH GROUP, INC., et al.,
Defendants.

VIDEO DEPOSITION OF
KENT BRISTOW
Wednesday, April 12, 2023
9:15 a.m ET

Reported by: Elisabeth A. Lorenz: RMR, CRR
Job No. 448508

KENT BRISTOW
EMERGENCY PHYSICIAN vs UNITEDHEALTH

April 12, 2023
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1 an alteration for that.

2 Now, again, if something has
3 historically been out of network, it's just factored
4 into the baseline foundation of what you've been
5 collecting for that plan out of network.

6 BY MR. JACOB:

7 Q So once you go out of network, you don't
8 know what rate to expect to receive from a given
9 payor; is that correct?

10 MR. FINEBERG: Object to form.

11 THE WITNESS: We know what rate to
12 expect. We don't know what rate they'll pay.

13 BY MR. JACOB:

14 Q So let's call it Payor X.

15 How do you find out what rate to expect to
16 receive from them out of network?

17 A Again, if it's an out-of-network plan, we
18 would either expect it to pay the full billed
19 charges that we bill out on the claim or access one
20 of our, you know, numerous rental network agreements
21 that we talked about earlier in which they would pay
22 generally a small discount off those bill charges.

23 Q So if they're out of network, you would
24 expect them to pay the full billed charges; is that
25 correct?

KENT BRISTOW
EMERGENCY PHYSICIAN vs UNITEDHEALTH

April 12, 2023
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1 MR. FINEBERG: Object to form,
2 mischaracterizes his testimony.

3 THE WITNESS: Or a small discount off
4 of those bill charges based upon, again, one of the
5 numerous rental network agreements that we have in
6 place that's an option for the plan to access.

7 BY MR. JACOB:

8 Q And your -- that's your expectation for an
9 out-of-network commercial payor, correct? They
10 either pay your full billed charges or a small
11 discount off of your full billed charges?

12 A Yes, because we believe our full billed
13 charges are a reasonable value for the services that
14 we're providing.

15 Q And the amount that you expect to receive is
16 what you put into the financial reporting, correct?

17 A Again, I said that ultimately the financial
18 reporting system is reflecting actual payment
19 activity. And so, again, just because we expect it,
20 and we do, but that's why we're in this proceeding
21 today is that the plans don't often comply with
22 those standards and our expectations and why we have
23 to pursue a dispute.

24 Q Well, the financial reporting is actually
25 forward looking, correct; it's not just backwards



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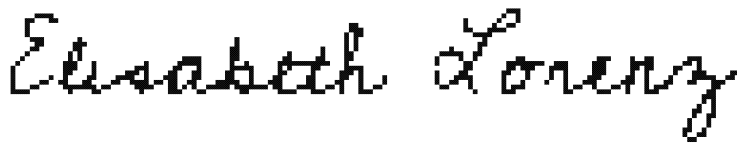
KENT BRISTOW
EMERGENCY PHYSICIAN vs UNITEDHEALTH

April 12, 2023
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CERTIFICATE OF SHORTHAND REPORTER

I, ELISABETH A. LORENZ, Registered Merit Reporter and Certified Realtime Reporter, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my direction; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand this 17th day of April, 2023.



ELISABETH A. LORENZ

NCRA Registered Merit Reporter

NCRA Certified Realtime Reporter

Exhibit 20

KENT BRISTOW
GULF-TO-BAY ANESTHESIOLOGY vs UNITEDHEALTHCARE

June 29, 2022

1

IN THE CIRCUIT COURT FOR THE THIRTEENTH
JUDICIAL CIRCUIT IN AND FOR
HILLSBOROUGH COUNTY, FLORIDA

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,
Plaintiff,

vs.

CASE NO. 2017-CA-011207

UNITEDHEALTHCARE OF FLORIDA, INC.,
AND UNITEDHEALTHCARE INSURANCE CO.,
Defendants.

~~~~~

DEPOSITION OF  
KENT BRISTOW, CORPORATE REPRESENTATIVE, DAY 2

June 29, 2022

9:09 a.m.

Paine, Tarwater, Bickers, LLP  
900 South Gay Street, Suite 2200  
Knoxville, Tennessee 37902

Shafaq Sameen Shabbir, 827



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UHC0012107

KENT BRISTOW  
GULF-TO-BAY ANESTHESIOLOGY vs UNITEDHEALTHCAREJune 29, 2022  
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1 THE WITNESS: So we believe they should have  
2 paid our provider charges. What was the prices  
3 billed for our services as we deem those to be usual  
4 and customary and reasonable in the market, based  
5 upon the studies that we've done. We do  
6 acknowledge, however, that under the statutory  
7 framework and the -- and the common law claims that  
8 we're putting forth, that the ultimate damages in  
9 this matter will be taxed later upon that statutory  
10 framework basis.

11 But, but coming back, I believe, and we believe  
12 that we should have been paid our charges that we  
13 billed because they are reasonable in the market for  
14 the services that we provided based upon the studies  
15 and evaluations we have done, and that's also  
16 consistent with United's own stated language and  
17 stated positions. So we're very much in agreement  
18 about that, about what they should have paid for the  
19 services based upon their own, you know, disclosures  
20 about those situations.

21 BY MR. FEDER:

22 Q. To be clear then, Mr. Bristow, you're saying  
23 that Gulf-To-Bay's position is United should have used  
24 100 percent of Gulf-To-Bay's billed charges for purposes  
25 of calculating the allowed amount on the disputed claims



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EsquireSolutions.com

1 in this case, correct?

2 MR. FINEBERG: Object to form. Misstates his  
3 testimony.

4 THE WITNESS: Again, I believe we should have  
5 been paid our charges. I would say also, though,  
6 that they certainly had access to rental network  
7 agreements that were available to them that would  
8 provide, again, value for a small discount, which  
9 they did, in fact, access for many claims that are  
10 not in the disputed category. So, again, we believe  
11 they should have been paid our full billed charges,  
12 given that they're reasonable and or a small  
13 discount of those charges that were available  
14 through them, that they accessed frequently through  
15 the rental network agreements. That all claims  
16 should have been handled that way.

17 BY MR. FEDER:

18 Q. When you say all claims should have been  
19 handled that way, you're talking about all  
20 out-of-network claims should have been paid under a wrap  
21 or rental network arrangement?

22 MR. FINEBERG: Object to the form.

23 THE WITNESS: All the disputed claims they'd  
24 have paid at the usual and customary level as were  
25 the claims in this case that we're not disputing.

KENT BRISTOW  
GULF-TO-BAY ANESTHESIOLOGY vs UNITEDHEALTHCARE

June 29, 2022  
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CERTIFICATION

I, SHAFaq SAMEEN SHABBIR, a Shorthand  
Reporter and notary public, do hereby certify:

That KENT BRISTOW, the witness whose  
examination is hereinbefore set forth, was first duly  
sworn in by me and that this transcript of said  
testimony is a true record of the testimony given by  
said witness.

I further certify that I am not related to  
any of the parties to this action by blood or marriage,  
and that I am in no way interested in the outcome of  
this matter.

IN WITNESS WHEREOF, I have hereunto set my  
hand this 5TH, day of JULY, 2022.

*Sameen Shabbir*

SHAFaq SAMEEN SHABBIR

# Exhibit 21

DEPOSITION OF KENT BRISTOW  
30(B)(6) WITNESS FOR TEAM PHYSICIANS

MAY 13, 2021

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES  
(MANDAVIA), LTD., a Nevada  
professional corporation; TEAM  
PHYSICIANS OF NEVADA-MANDAVIA,  
P.C., a Nevada professional  
corporation; CRUM, STEFANKO AND  
JONES, LTD., dba RUBY CREST  
EMERGENCY MEDICINE, a Nevada  
professional corporation,

Case No.  
A-19-792978-B  
Dept. No.: 27

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., UNITED  
HEALTHCARE INSURANCE COMPANY, a  
Connecticut corporation; UNITED  
HEALTH CARE SERVICES, INC., dba  
UNITEDHEALTHCARE, a Minnesota  
corporation; UMR, INC., dba UNITED  
MEDICAL RESOURCES, a Delaware  
corporation; OXFORD HEALTH PLANS,  
INC., a Delaware corporation;  
SIERRA HEALTH AND LIFE INSURANCE  
COMPANY, INC., a Nevada  
corporation; SIERRA HEALTH-CARE  
OPTIONS, INC., a Nevada  
corporation; HEALTH PLAN OF  
NEVADA, INC., a Nevada  
corporation; DOES 1-10; ROE  
ENTITIES 11-20,

Defendants.

Job No. 758196



30(B)(6) FOR TEAM PHYSICIANS KENT BRISTOW - 05/13/2021

Page 318

1 **claims in the Complaint." Do you see that?**

2 A. Yes.

3 **Q. Is it Team Physicians' position that the**  
4 **fair value of the at-issue claims in the Complaint is**  
5 **the full-boat charges?**

6 A. Yes, based on that being the usual and  
7 customary charges.

8 **Q. And is it Team Physicians' position that**  
9 **there is no reimbursable amount below billed charges**  
10 **that would be fair value for the at-issue claims in the**  
11 **case?**

12 MR. FINEBERG: Object to form.

13 THE WITNESS: Repeat that question.

14 BY MR. BLALACK:

15 **Q. Sure. Is it Team Physicians' position**  
16 **that there is no amount or rate below billed charges**  
17 **for the at-issue claims that would constitute fair**  
18 **value?**

19 MR. FINEBERG: Object to the form.

20 THE WITNESS: In this situation in these  
21 circumstances for the claims that are -- that are  
22 at dispute, yes, I agree with that.

23 BY MR. BLALACK:

24 **Q. There is none; it's billed charges and**  
25 **that's it, correct?**

30(B) (6) FOR TEAM PHYSICIANS KENT BRISTOW - 05/13/2021

Page 319

1 A. Given that it's the usual and customary  
2 charge, yes.

3 Q. Okay. All right. Thank you, sir. You  
4 can set that aside.

5 Actually, I want to direct you to Subject  
6 Matter 35, if you'd go to the end of the notice, Exhibit  
7 1. And you'll see, sir, that there's a series of topics,  
8 questions -- strike that.

9 A series of topics discussing Team  
10 Physicians' document retention policies. Do you see  
11 that?

12 A. Yes.

13 Q. What did you do to prepare to give  
14 testimony on Subject Matter 35 today?

15 A. I prepared some notes associated with  
16 those matters.

17 Q. And where did you get the information  
18 that you prepared the notes on?

19 A. In consultation with our attorneys.

20 Q. Okay. Did you review any documents to  
21 assist you in testifying in response to Subject Matter  
22 35?

23 A. No, I did not.

24 Q. Okay. So what -- all the content of the  
25 notes -- and by the way, the notes you're referring to

30(B) (6) FOR TEAM PHYSICIANS KENT BRISTOW - 05/13/2021

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1 C E R T I F I C A T E

2

3 STATE OF TENNESSEE

4 COUNTY OF KNOX

5 I, Rhonda S. Sansom, RPR, CRR, CRC, LCR #685,

6 licensed court reporter in and for the State of

7 Tennessee, do hereby certify that the above

8 videoconference deposition of KENT BRISTOW as the

9 30(b) (6) witness for Plaintiff Team Physicians was

10 reported by me and that the foregoing 324 pages of the

11 transcript is a true and accurate record to the best of

12 my knowledge, skills, and ability.

13 I further certify that I am not related

14 to nor an employee of counsel or any of the parties to

15 the action, nor am I in any way financially interested

16 in the outcome of this action.

17 I further certify that I am duly licensed

18 by the Tennessee Board of Court Reporting as a Licensed

19 Court Reporter as evidenced by the LCR number and

20 expiration date following my name below

21

22

23

24

25

Rhonda S. Sansom, RPR, CRR, CRC  
Tennessee LCR# 0685  
Expiration Date: 6/30/22

# Exhibit 22

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

|                                   |   |               |
|-----------------------------------|---|---------------|
| -----                             | X |               |
| EMERGENCY PHYSICIAN SERVICES OF   | * |               |
| NEW YORK, et al.,                 | * |               |
|                                   | * |               |
| Plaintiffs,                       | * | CASE NO.      |
|                                   | * | 1:20-CV-09183 |
| vs.                               | * | -JGK-SN       |
|                                   | * |               |
| UNITEDHEALTH GROUP, INC., et al., | * |               |
|                                   | * |               |
| Defendants.                       | * |               |
| -----                             | X |               |

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ATTORNEYS' EYES ONLY

VIDEOTAPED 30(b)(1) and 30(b)(6) DEPOSITION  
OF PAUL A. BEVILACQUA  
Philadelphia, Pennsylvania  
Friday, March 17, 2023

Reported by:

Elizabeth M. Kondor, CCR

JOB NO. 223596

1 PAUL A. BEVILACQUA

2 Physician Associates.

3 Q. Got it.

4 And how long were you employed by  
5 Emergency Physician Associates at the time that  
6 it had that nomenclature?

7 A. I was there for -- it had the  
8 nomenclature a little bit longer because we  
9 still went by that name, but about three years,  
10 and then it was acquired by TeamHealth in 1996.

11 Q. Got it.

12 So prior to that acquisition, what  
13 was your role within Emergency Physician  
14 Associates?

15 A. I was the director of reimbursement.

16 Q. Got it.

17 Did you say "services" or  
18 "associates"? I'm sorry.

19 A. Associates.

20 Q. Associates. Yeah, okay.

21 Then after that, where did you go --  
22 what did you do with TeamHealth after --  
23 post-acquisition?

24 A. Well, I was still the director of  
25 reimbursement.

1 PAUL A. BEVILACQUA

2 Q. Okay.

3 And are you still in that role now?

4 A. No. Now I'm the vice president of  
5 managed care.

6 Q. Okay.

7 And walk us through what led from  
8 your -- the beginning role to where you are  
9 now.

10 What other jobs did you have within  
11 TeamHealth?

12 A. Pretty much the same role; working  
13 with the managed care companies, and working  
14 with -- overseeing some of the billing on the  
15 revenue side.

16 Q. Got it.

17 Did your title ever change?

18 A. It did.

19 Q. Okay.

20 And what were the different titles  
21 that you've had?

22 A. Director, really, then to vice  
23 president.

24 Q. Got it. Okay.

25 And do you report to anyone

1 PAUL A. BEVILACQUA

2 currently?

3 A. I do.

4 Q. Who do you report to?

5 A. Kent Bristow.

6 Q. Okay.

7 Anyone else or is he your only

8 report?

9 A. He's my only.

10 Q. And do you have any direct reports  
11 underneath you?

12 A. I do.

13 Q. Who?

14 A. Lisa Zima.

15 Q. Anyone else?

16 A. Daphne Maxwell. She's like an  
17 administrative person.

18 Q. Gotcha.

19 And anyone else besides those two?

20 A. No.

21 Q. Okay.

22 So when -- getting to the substance  
23 of the deposition now, and just so you know,  
24 I'm going to say "TeamHealth" for a lot of  
25 these questions within the 30(b)(1) portion of



1 PAUL A. BEVILACQUA

2 patient's lap. But that discount depends on  
3 other circumstances.

4 Q. I completely understand.

5 But those would still be fair, even  
6 though it's less than full billed charges?

7 A. It depends.

8 Q. Okay.

9 Well, "it depends" means sometimes  
10 it's fair; sometimes it's not fair.

11 Can we agree to that?

12 A. Yes.

13 Q. Okay.

14 Let's switch it to the  
15 out-of-network perspective.

16 A fair reimbursement rate there,  
17 would you agree it's still full billed charges?

18 A. Yes, absolutely.

19 Q. Okay.

20 Have you accepted out-of-network --  
21 has TeamHealth, when I say you, TeamHealth  
22 accepted out-of-network rates that are less  
23 than full billed charges without dispute,  
24 without appeal, anything like that?

25 A. No, we typically dispute anything

1 PAUL A. BEVILACQUA

2 that's less than full billed charges --

3 Q. Okay.

4 A. -- as out of network.

5 Q. Okay.

6 And when you dispute it, do you  
7 sometimes come to a resolution with the payer?

8 A. I'm not involved in the disputes.

9 Q. Got it.

10 So is it a practice that, whenever  
11 TeamHealth receives full -- less than full  
12 billed charges on an out-of-network claim, they  
13 will always dispute it?

14 A. Yes.

15 Q. Okay.

16 And you don't know whether or not --  
17 after it reaches a dispute phase, you never see  
18 what the resolution of that dispute is.

19 Is that right?

20 A. Correct.

21 Q. Who would see that?

22 A. There's people that do that. You'd  
23 have to ask Kent Bristow that.

24 Q. Ask Kent Bristow. Got it.

25

1 PAUL A. BEVILACQUA

2 C E R T I F I C A T E

3 I, ELIZABETH M. KONDOR, a Certified  
4 Court Reporter, License ##30XI00117200, and  
5 Notary Public of the Commonwealth of  
6 Pennsylvania, do hereby certify that prior to  
7 the commencement of the examination, PAUL A.  
8 BEVILACQUA was duly sworn by me to testify the  
9 truth, the whole truth and nothing but the  
10 truth.

11 I DO FURTHER CERTIFY that the  
12 foregoing is a true and accurate transcript of  
13 the testimony as taken stenographically by and  
14 before me at the time, place and on the date  
15 hereinbefore set forth.

16 I DO FURTHER CERTIFY that I am  
17 neither a relative nor employee nor attorney nor  
18 counsel of any of the parties to this action,  
19 and that I am neither a relative nor employee of  
20 such attorney or counsel, and that I am not  
21 financially interested in the action.

22 *Elizabeth Kondor*  
23

24 Elizabeth M. Kondor, CCR  
25 Notary Public/Commonwealth of Pennsylvania  
My Commission expires July 28, 2026.  
Dated: March 27, 2023

# Exhibit 23

**From:** Leif Murphy <leif\_murphy@teamhealth.com>

**To:** Wiechart Mike <michael\_wiechart@teamhealth.com>, David Jones <David\_Jones@teamhealth.com>, Joe Carman <Joe\_Carman@teamhealth.com>, "Bristow Kent" <Kent\_Bristow@teamhealth.com>, Carol Owen <Carol\_Owen@teamhealth.com>, Lynn Massingale <hlmass1979@gmail.com>, Phil McSween <phil\_mcsween@teamhealth.com>

**Subject:** UHG Meeting

**Date:** Thu, 18 Apr 2019 19:17:51 -0400

**Importance:** Normal

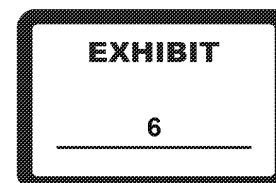
**Attachments:** new\_doc\_2019-04-18\_17.55.08.pdf

I just finished up the UHG meeting with Dan Schumacher. It lasted just under 2 hours. In the spirit of memorializing the conversation ([REDACTED]), here is an abbreviated play-by-play:

- Brief introductions by Dr. Galvin who turned it over to me.
- I said that I assumed Dan wouldn't know the minutia of ED and took him through the basics: \$150 average cost per encounter; 75% of encounters are paid below cost; MCR approximates cost because of the efficiencies that we have to drive every year – not because of a COLA; volume trends; impact of commercial alternate site strategies on our ability to leverage cost and provider rate; need for 4 to 6% commercial increases to get us to medical cost inflation.
- UHG's actions, particularly in the face of soft volume are financially unsustainable.
- We don't balance bill; we've pursued litigation as a strategy; 0 suits in '16 / 17 suits by '18; settled 4 in 1Q on eve of trial at over 475% of MCR with inflators; UCR ultimately defined by our in-network rates with the same payor, rates from other payors, and rates from the defendant to other providers.
- Just filed 4 against UHG; [REDACTED] we expect to prevail based on state and federal law; better tactic than billing the patient; very expensive – we spent \$9mm last year and expect to spend \$10mm this year.

Turned it over to Dan. [REDACTED] He recapped:

- Been trying to negotiate with TeamHealth since 2017. They're being exploited.
- Took all OON providers to 350% of Medicare on 1/1/18 but spared us; saved us \$47mm.
- Their goal is to level the playing field for their ASO clients that have not been willing to put the patient in the middle. More are signing up for the dramatic reimbursement cuts for OON providers.
- Our last offer of 460% of Medicare was way off the mark.
- Turned on benchmark pricing for us 1/1/19 since we weren't reasonable.
- 4/1/19 they plan to ratchet down to 250%.
- Sees what we did with provider Tax ID #s. By example, we had 15 providers in our % of charge contract in OH and now it's 85.
- He wants a big step down from us to less than 400% and then more from there. No dialogue happens above that amount. Why the ratchet down to 250%? Because they can.
- Expressed intense frustration about the BCBS rates relative to ours. Gave me an analysis based on our Cassidy data (attached).
- Wants to be open book on his next steps: 4/1/19 rate cut; Terminate Ohio and other states that we've meddled with for breach of contract. Will progressively terminate in-network contracts at renewals. Take us to 250% across the board.



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My response:

- I completely understand how he feels. The multiple cross-subsidies are frustrating to everyone. We would rather collaborate than see them run their playbook. Given the amount of time we've each had to prepare, the public fight is going to be ugly – especially in the face of people clamoring for Medicare for All.
- We can't accept the rates they're proposing. Catastrophic for us. With less than \$350mm in EBITDA and 8x leverage, he can do the math – we don't have a choice but to fight.
- Neil weighed in here with real conviction confirming this point.
- Looking at the first play in his playbook, we actually followed all of the notification rules when we moved Tax ID numbers (go check), so you won't find a breach. We've gotten really good at the litigation route and have a template to file in every state for every contract. As you're about to learn in the 4 we filed our goal is to get them to trial asap. We already have our supporting data to drop-in so the real work is discovery and deposition on the payor side [REDACTED] Our confidence level from experience is really high that we'll ultimately prevail at over 475%. For every UHG termination, we'll file a TeamHealth lawsuit.
- In the same spirit of full disclosure he shared with us: At the end of 2018 we didn't have any employer lawsuits. Our litigators feel highly confident that there is culpability on the employer side with the arbitrary reduction in payments, the harm it is causing and the cross-subsidy created within UHG's ASO/fully-insured business. We are starting direct contracting discussions with the employers as we speak. If we're unsuccessful, we will have helped employers understand why we need to bring them in as parties to the lawsuits. My expectation is that we will have at least 5 lawsuits with UHG's largest employer customers by the end of 2019. I volunteered to connect his legal team with ours to go through the legal underpinnings.

From there it became a long negotiation. I shared with him the rates that we had bought around the country and why it solidifies our litigation posture – so we don't plan to start anywhere below that outcome. I said that I wasn't aware of the 460% offer that we had made ([REDACTED]), but that it was unacceptable to us. He believed 460% was a \$35mm concession on our part. He didn't know if it was inclusive of ANX. I told him we couldn't do it for EM, and there was no way we could do it if ANX was included.

I did say that on EM alone, we could agree on something between 460% and 495%, but that we also needed to resolve ANX.

Bob ended by weighing in on the possibility of a bigger relationship with BX on both the PBM and health insurance fronts.

At the end of the meeting, Dan said he was going to "go have a drink" and look at the numbers again. The plan is for him to call me Monday...

**Leif Murphy**

President and Chief Executive Officer

TeamHealth

265 Brookview Centre Way, Suite 400 | Knoxville, TN 37919

office: 865.293.5300 | email: [leif\\_murphy@teamhealth.com](mailto:leif_murphy@teamhealth.com)

[www.teamhealth.com](http://www.teamhealth.com) | facebook.com/teamhealth | @TeamHealth

*Fortune "World's Most Admired Companies" – 2015, 2016, 2017*

*Becker's Hospital Review "150 Great Places to Work in Healthcare" – 2015, 2016, 2017*

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FESM008946  
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4918 - 000003

## Team Health- United Contribution and Comparison to Blues

## Estimated ER Book of Business

| Payer Mix          | Total |               | United        |               | Blues   |         |
|--------------------|-------|---------------|---------------|---------------|---------|---------|
|                    | Share | Rev Per Visit | Rev Per Visit | Rev Per Visit | Revenue | Revenue |
| Medicare           | 25%   | \$145         |               |               |         |         |
| Medicaid           | 33%   | 75            |               |               |         |         |
| Self-Pay           | 16%   | 34            |               |               |         |         |
| Commercial         | 26%   | 350           | \$652         | \$251         |         |         |
| Weighted per Visit |       | \$157         |               |               |         |         |
| Cost Per Visit     |       | \$150         | \$150         | \$150         |         |         |
| Margin per Visit   |       | \$7           | \$502         | \$101         |         |         |

| Payer Mix          | Total |               | United- at Proposal |               | Blues   |         |
|--------------------|-------|---------------|---------------------|---------------|---------|---------|
|                    | Share | Rev Per Visit | Rev Per Visit       | Rev Per Visit | Revenue | Revenue |
| Medicare           | 25%   | \$145         |                     |               |         |         |
| Medicaid           | 33%   | 75            |                     |               |         |         |
| Self-Pay           | 16%   | 34            |                     |               |         |         |
| Commercial         | 26%   | 350           | 445                 | 251           |         |         |
| Weighted per Visit |       | \$157         |                     |               |         |         |
| Cost Per Visit     |       | \$150         | \$150               | \$150         |         |         |
| Margin per Visit   |       | \$7           | \$295               | \$101         |         |         |

## Dollar Margin Breakdown

| Total          |
|----------------|
| (\$19,636,824) |
| (388,809,122)  |
| (291,567,568)  |
| 816,891,892    |
| \$116,878,378  |

$\frac{116,878,378}{1,429,560,811} = 8.17\%$   
 $\frac{116,878,378}{1,429,560,811} = 8.17\%$

$\frac{116,878,378}{1,429,560,811} = 8.17\%$   
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Source and Assumptions: Team Presentation "United HealthCare Developing a Collaborative National Solution to Address Surprise Billing"

Estimated market share difference between United and all Blues plans nationally (Blues 3x United)

United (500%) and Blues (192%) per visit based on Medicare relativity and then discounted by identified collection (50% of 20% cost share).

CONFIDENTIAL AND PROPRIETARY: United considers the data and analysis in this document to be confidential and proprietary business information, as it contains specific information regarding United's pricing and analytic approach. The following analysis is based on United's own data as well as certain high-level information regarding TeamHealth's payer/reimbursement mix provided to United by Lief Murphy.



# Exhibit 24

IN THE DISTRICT COURT OF CLEVELAND COUNTY  
STATE OF OKLAHOMA

EMERGENCY SERVICES OF OKLAHOMA, )  
PC, OKLAHOMA EMERGENCY SERVICES )  
PC, SOUTH CENTRAL EMERGENCY )  
SERVICES PC, and EMERGENCY )  
PHYSICIANS OF MID-AMERICA PC, )  
PLAINTIFFS, )  
V. ) CASE NO. CJ-2019-482  
UNITED HEALTHCARE INSURANCE )  
COMPANY, UNITED HEALTHCARE )  
SERVICES INC., and UNITED )  
HEALTHCARE OF OKLAHOMA INC., )  
DEFENDANTS. )

\*\*\*\*\*  
TRANSCRIPT OF JURY TRIAL  
DAY 11  
HAD ON THE 17TH DAY OF APRIL, 2024,  
BEFORE THE HONORABLE  
THAD BALKMAN, DISTRICT JUDGE.  
\*\*\*\*\*

REPORTED BY: Tanya Burcham, CSR, RPR, CRR  
Official Court Reporter  
200 South Peters  
Norman, OK 73069

DISTRICT COURT OF OKLAHOMA - OFFICIAL TRANSCRIPT

1 Q. (By Mr. Trach) So what this shows, that is, as of  
2 2018, for all TeamHealth claims with Blue Cross Blue Shield,  
3 United, you had an average allowed amount of 262 and as a  
4 percent of Medicare, that's 192 percent. Right?

5 A. That's right.

6 Q. Okay. So you testified on direct about a meeting  
7 that you had with Dan Schumacher and some others at United in  
8 the middle of April 2019.

9 Do you remember that?

10 A. That's correct.

11 Q. And before that meeting, you sent him a letter  
12 discussing your position on the negotiations in advance of the  
13 meeting. Right?

14 A. I did.

15 Q. Okay.

16 MR. TRACH: Your Honor, I would offer DX377.

17 MR. AHMAD: No objection, Your Honor.

18 MR. TRACH: Your Honor, may I approach?

19 THE COURT: You may.

20 377 will be admitted into the evidence.

21 Q. (By Mr. Trach) Okay. So DX377 is an email with an  
22 attachment that contains the letter that you sent to him.  
23 Right?

24 A. That's correct.

25 Q. And you told him, "I'm attaching some background

1 material on our TeamHealth-UHC relationship for discussion in  
2 the meeting."

3 Right?

4 A. That's correct.

5 Q. And it said, Dan Schumacher was the president and  
6 chief operating officer at United at the time. Right?

7 A. That's right.

8 Q. And if we look at the letter, you drafted and signed  
9 it. Right?

10 A. That's correct.

11 Q. That's your signature at the bottom. Right?

12 A. That's right.

13 Q. Okay. So one of the --

14 MR. TRACH: Let's go to the first page of the  
15 letter, please, Gayle.

16 Q. (By Mr. Trach) So the first thing you say is,  
17 "Thank you for sending Bob Galvin your March '19 letter to the  
18 House and Senate committee chairs' ranking efforts."

19 Do you see that?

20 A. Yes.

21 Q. Okay. So you had sent a letter to Senator Cassidy.  
22 Right?

23 A. That's right, I did.

24 Q. And United gets sent one as well. Right?

25 A. That's right.

1 Q. In fact, you filed the lawsuit in this case on the  
2 very same day you sent this letter. Right?

3 A. That's probably right, yes.

4 Q. Okay. And two days before, you were set to have a  
5 meeting with him to try to reach an agreement on a network  
6 rate. Right?

7 A. Yes.

8 Q. Okay. Then on the second-to-last paragraph you say  
9 what your objective for the meeting is. Right?

10 And you say, "Our objective is to, number 2, bring our  
11 out-of-network geographies in network at rates comparable to  
12 our current in-network rates of 495 percent of Medicare."

13 Right?

14 A. That's right.

15 Q. So that -- what you were asking for was -- was  
16 495 percent of Medicare. Right?

17 A. That's right.

18 Q. Okay. On average, in 2018 you had been getting, we  
19 said, about 265 percent. Right?

20 A. By that math, yes.

21 Q. Okay. And you were getting 192 percent from  
22 Blue Cross. Right?

23 A. That's correct.

24 Q. And you were asked that -- was that United pay  
25 495 percent. Right?

1 A. That's right.

2 Q. And then let's look at the third thing you say.

3 You said, "I want to collaborate on a federal solution  
4 that eliminates surprise balance bills, ultimately levels the  
5 playing field for commercial reimbursement, and advances the  
6 need for governmental increases."

7 Do you see that?

8 A. I do.

9 Q. Okay. And essentially what you're saying to  
10 Mr. Schumacher is, I want you to agree to pay us 495 percent of  
11 Medicare and then let's work together to get legislation passed  
12 that will require the Blues and the others to essentially pay  
13 the same amount as you; your rates will come down and their  
14 rates will come up. Right?

15 A. Including Medicare and Medicaid, yes.

16 Q. So after you sent that letter, you -- you met with  
17 Mr. Schumacher. Right?

18 A. I did.

19 MR. TRACH: Actually, Gayle, let's bring that back  
20 up, please. I'm sorry.

21 Q. (By Mr. Trach) Because in answering my question,  
22 you said "including Medicare and Medicaid," but when you talked  
23 about leveling the playing field, you said "levels the playing  
24 field for commercial reimbursement."

25 Right?

1 THE COURT: Defendants' 368 will be admitted into  
2 the evidence.

3 MR. TRACH: May I approach?

4 THE COURT: Yes.

5 Q. (By Mr. Trach) Okay. This is the same email that  
6 you had eventually forwarded to Keith Sherin, but this time  
7 after you wrote the email to your team, you forwarded it to  
8 Neil Simpkins. Right?

9 A. That's right.

10 Q. And obviously he was at the meeting, but you say,  
11 "In case your team was asking for updates, here is a quick  
12 summary I sent to my team."

13 Right?

14 A. Yes.

15 Q. So you talked about this very briefly in your  
16 direct. And I would like to talk about this meeting in a  
17 little more detail. Okay?

18 A. Okay.

19 Q. So these are essentially your quick notes from the  
20 discussion after it happened. Right?

21 A. That's right.

22 Q. And you start off by saying that it began with brief  
23 introductions by Dr. Galvin, who turned it over to you. Right?

24 A. That's right.

25 Q. Dr. Galvin is one of your board members and, as we

1 said earlier, he is the CEO of Equity Healthcare, one of  
2 Blackstone's portfolio companies. Right?

3 A. That's right.

4 Q. And you assumed that Dan wouldn't know the minutia  
5 of emergency department and took him through the basics.  
6 Right?

7 A. That's right.

8 Q. And that some of the stuff after that are some of  
9 the stats that were in the Cassidy letter. Right?

10 A. That's correct.

11 Q. And you said that their actions are financially  
12 unsustainable. Right?

13 You don't balance bill and that you pursue litigation as  
14 a strategy. Right?

15 A. That's right.

16 Q. Basically the things that you said in your letter  
17 you summarized again for them in the meeting?

18 A. That's right.

19 Q. And part of the reason that you told him that you  
20 pursued litigation strategy or the reason that you told him  
21 that you had recently filed a bunch of lawsuits against United  
22 was that you were hoping that that would give you leverage in  
23 your negotiation with them. Right?

24 A. Yes, knowing that we don't balance bill, without  
25 having a litigation, the less they pay, the more they make.



1 There's no recourse.

2 Q. And you're the one who was ultimately responsible  
3 for deciding to file those lawsuits. Right?

4 A. That's correct.

5 Q. And you did that with the support of the board?

6 A. I did.

7 Q. Okay. And that was unanimous, including the  
8 Blackstone members. Right?

9 A. There were no objections. I don't think we voted.

10 Q. Okay. And the lawsuits were filed by the individual  
11 provider entities like the plaintiffs in this case, not  
12 TeamHealth. Right?

13 A. That's correct.

14 Q. And the doctors practicing at the plaintiff entities  
15 were not informed prior to TeamHealth filing these lawsuits.  
16 Right?

17 A. Not immediately, no.

18 Q. Okay. So let's turn to what Mr. Schumacher said in  
19 his responses. Right. So let's look at your comment.

20 First you turned it over to Dan and you wrote, "He knew  
21 his stuff."

22 Right?

23 A. Yeah.

24 Q. And I think when we talked about this in your  
25 deposition, and I think what you meant to convey by that was

1 that oftentimes when you're speaking with a high-level  
2 executive like this, you don't expect them to be sort of in the  
3 details and in the weeds, and he definitely was and you were  
4 surprised by that. Right?

5 A. That's right.

6 Q. And first thing you said was that they had been  
7 trying to negotiate with TeamHealth since 2017, which we know  
8 is right. Right?

9 A. Uh-huh.

10 Q. And then he said that they're "being exploited."  
11 Right?

12 A. Yeah.

13 Q. And what he said -- the reason he said that was  
14 because that United was paying way more than other commercial  
15 payers, including Blue Cross. Right?

16 A. Yes.

17 Q. Okay. And you knew at the time that a substantial  
18 portion of the United patients who were being seen by  
19 TeamHealth ER doctors were covered pursuant to an ASO plan.  
20 Right?

21 A. Yes.

22 Q. I mean, you knew that because your employees were  
23 covered by an ASO plan that United was administering. Right?

24 A. That's right.

25 Q. And what that means, that while United is the one

1 you. Right?

2 A. Yes.

3 Q. Okay. And he even provided you an analysis of what  
4 United and its ASO customers allowed on average compared to  
5 what Blue Cross was allowing. Right?

6 A. He did.

7 Q. And that was attached to -- he gave it to you in the  
8 meeting and you attached it to this. Right?

9 A. I did.

10 MR. TRACH: Can we just take a quick look at it,  
11 Gayle, please.

12 Q. (By Mr. Trach) That's United contribution and  
13 comparison to the Blues. This is the analysis that he prepared  
14 in preparing United's contribution to the Blues based on the  
15 numbers that were contained in the Cassidy letter. Right?

16 A. That's right.

17 Q. Okay.

18 MR. TRACH: Gayle, let's go back to the email,  
19 please.

20 Q. (By Mr. Trach) So in your words, and that's the  
21 second bullet from the bottom, "He expressed intense  
22 frustration about the Blue Cross rates relative to United's."  
23 Right?

24 A. That's correct.

25 Q. And as we discussed earlier, that frustration was

1 based on the fact that the United patients, who were going to  
2 see your doctors, were paying far more than what the Blue Cross  
3 patients were paying to see your doctors. Right?

4 A. That's right.

5 Q. And essentially one of the things that  
6 Dan Schumacher told you in that meeting was the fact that  
7 United was -- the fact that United was paying so much more than  
8 Blue Cross, one of their competitors for the same care, was not  
9 reasonable. Right?

10 A. That's right.

11 Q. And let's talk about how you responded. You  
12 responded by saying that you completely understand how he  
13 feels. Right?

14 A. Right.

15 Q. That multiple cross-subsidies are frustrating to  
16 everyone. Right?

17 A. That's right.

18 Q. Okay. And what you were saying was that you  
19 understand, that you're frustrated that United's ASO clients  
20 are subsidizing Blue Cross's ASO clients. Right?

21 A. What I'm saying is everyone was frustrated. We have  
22 to essentially cross-subsidize the uninsured, Medicaid,  
23 Medicare. And I'm sure he would be frustrated by the Blues as  
24 well.

25 Q. Okay. And then you say, "We would rather

1 collaborate than see them run their playbook."

2 And by that, you were referring to the -- reducing the  
3 out-of-network rates pursuant to their benchmark program.

4 Right?

5 A. That's right.

6 Q. And then you say, "Given the amount of time we've  
7 each had to prepare, the public fight is going to be ugly."

8 Right?

9 A. (Nods head affirmatively.)

10 Q. That's what you told them?

11 A. Yeah.

12 Q. Okay. And then let's go down to the fourth bullet.

13 You tell him two additional things. Right?

14 First, you told him that, in addition to the lawsuits you  
15 had already filed, including this one, you were going to file  
16 additional lawsuits against United in other states. Right?

17 A. Yes, if they continued down the paths.

18 Q. Okay. And then what you told them in the last  
19 bullet was that, in addition to suing United, you were going to  
20 sue several of their largest ASO customers. Right?

21 A. That's right.

22 Q. And finally, you told Mr. Schumacher if they didn't  
23 come to the table with rates that you wanted, you were going to  
24 terminate TeamHealth's ASO contract. Right?

25 A. That's right.

CERTIFICATE

STATE OF OKLAHOMA       )  
COUNTY OF CLEVELAND    )

I, Tanya Burcham, a Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that I was present at the proceedings had April 17, 2024; that I recorded in stenotype notes all of said proceedings, that I thereafter transcribed my notes so taken and reduced same to typewritten form, and that the foregoing Transcript of Proceeding is full, true, correct and complete, to the best of my skill and ability.

I further certify that I am not an attorney for nor relative of any of said parties or otherwise interested in the outcome or event of said action.

**IN WITNESS WHEREOF**, I have hereunto set my hand and affixed my official seal this 17th day of April, 2024.

\_\_\_\_\_  
Tanya Burcham, CSR, RPR, CRR

# Exhibit 25



1 RTRAN

2  
3  
4  
5 DISTRICT COURT

6 CLARK COUNTY, NEVADA

7 )  
8 FREMONT EMERGENCY SERVICES )  
(MANDAVIS) LTD., ET AL., )

9 Plaintiffs, )

10 vs. )

11 UNITED HEALTHCARE )  
INSURANCE COMPANY, ET AL., )

12 Defendants. )  
13

14 BEFORE THE HONORABLE NANCY ALLF  
DISTRICT COURT JUDGE  
15 TUESDAY, NOVEMBER 16, 2021

16 **RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 13**

17 APPEARANCES:

18 For the Plaintiffs:

19 PATRICIA K. LUNDVALL, ESQ.  
JOHN ZAVITSANOS, ESQ.  
20 JASON S. MCMANIS, ESQ.  
JOSEPH Y. AHMAD, ESQ.  
21 KEVIN LEYENDECKER, ESQ.

22 For the Defendants:

23 D. LEE ROBERTS, JR., ESQ.  
K. LEE BLALACK, ESQ.  
JEFFREY E. GORDON, ESQ.  
24 DANIEL F. POLSENBERG, ESQ.  
LAUREN KENNEY, ESQ.

25 RECORDED BY: BRYNN WHITE, MARIA GARIBAY COURT RECORDERS



1 to.

2 MR. ZAVITSANOS: Yes, Your Honor.

3 MR. ROBERTS: Thank you, Your Honor.

4 BY MR. ROBERTS:

5 Q Mr. Murphy --

6 MR. ZAVITSANOS: Do we have a copy of that for the  
7 witness?

8 MR. ROBERTS: When I get to it, I'll get him a copy.

9 MR. ZAVITSANOS: Okay, okay, thank you. Thank you, Mr.  
10 Roberts.

11 FURTHER RECROSS-EXAMINATION

12 BY MR. ROBERTS:

13 Q I was just going back to a question I asked in front of the jury.  
14 The judge sustained the objection. You testified that one of the reasons  
15 you filed this lawsuit was for the clinicians and that included the  
16 physicians staffing the emergency rooms, correct?

17 A That's correct.

18 Q Under the physicians' various employment contracts and  
19 independent contractor agreements, is there a provision entitling them  
20 to a portion of the amount the jury awards in this case?

21 A In these particular contracts, I don't believe so.

22 MR. ROBERTS: Your Honor, if I could just give the witness a  
23 copy of 4918? Actually you can kind of look at it and hand it to her. And  
24 then we'll mark that copy as the Court's exhibit.

25 MR. ZAVITSANOS: And Mr. Roberts, can I just ask you what

1 you all redacted here.

2 MR. ROBERTS: That was your redactions in the original  
3 production.

4 MR. ZAVITSANOS: Oh, okay.

5 THE COURT: Is it 4918?

6 MR. ROBERTS: 4918.

7 THE COURT: Thank you.

8 MR. ZAVITSANOS: And this is the one the Court sustained  
9 the objection.

10 MR. ROBERTS: And I believe the redactions were made by  
11 TeamHealth in the original document productions.

12 MR. ZAVITSANOS: Thank you.

13 BY MR. ROBERTS:

14 Q And sir, you recognize this as an email which you wrote to  
15 other employees and officers at TeamHealth?

16 A I do.

17 Q And are there attorneys included on that list?

18 A Yes, there is.

19 Q Does this email summarize a meeting that you had with Dan  
20 Schumacher of UHG or United Health Group?

21 A Yes, it does.

22 Q So looking at that first bullet point, brief and productions by  
23 Dr. Galvin who turned it over to me. Who is Dr. Galvin?

24 A Bob Galvin is a member of our Board of Directors. And he is  
25 the CEO of Equity Healthcare.

1 MS. ROBINSON: Well, this was a warm, cooperative  
2 experience.

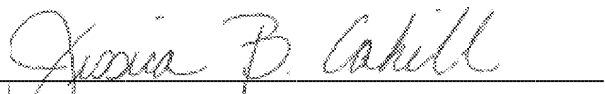
3 THE COURT: That's okay. Save your fights for the fight. See  
4 you guys in the morning. Have a great night.

5 MS. ROBINSON: Thank you, Your Honor.

6 MR. PORTNOI: Thank you, Your Honor.

7 [Proceedings adjourned at 5:52 p.m.]  
8  
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20 ATTEST: I do hereby certify that I have truly and correctly transcribed the  
21 audio-visual recording of the proceeding in the above entitled case to the  
22 best of my ability.

23   
24 Maukele Transcribers, LLC  
25 Jessica B. Cahill, Transcriber, CER/CET-708

# Exhibit 26

# EXHIBIT A

**K&L GATES LLP**

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EMERGENCY CARE SERVICES OF NJ, PA,  
EMERGENCY PHYSICIAN ASSOCIATES OF  
NORTH JERSEY, PC, EMERGENCY  
PHYSICIAN ASSOCIATES OF SOUTH  
JERSEY, PC, EMERGENCY PHYSICIAN  
SERVICES OF NEW JERSEY, PA,  
MIDDLESEX EMERGENCY PHYSICIANS,  
PA, and PLAINFIELD EMERGENCY  
PHYSICIANS, PA,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC.,  
UNITEDHEALTHCARE INSURANCE  
COMPANY, UNITEDHEALTHCARE OF  
NEW JERSEY, INC., and MULTIPLAN, INC.,

Defendants.

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: GLOUCESTER  
COUNTY

DOCKET NO. GLO-L-\_\_\_\_\_-20

Civil Action

**COMPLAINT AND JURY DEMAND**

For their Complaint against Defendants UnitedHealth Group, Inc. (“UHG”), UnitedHealthcare Insurance Company (“UHIC”), UnitedHealthCare of New Jersey, Inc. (“UHC-NJ”), and Multiplan, Inc. (“Multiplan”), the above-captioned Plaintiffs allege as follows:

## **INTRODUCTION**

1. This case is brought in the context of a global coronavirus pandemic, which has already infected over 9.2 million people and claimed over 231,000 lives in this country. The pandemic is ongoing, with new infections and deaths being reported every day. New Jersey has been especially hard hit. As of this writing, there have been over 241,000 cases and more than 16,000 confirmed deaths in New Jersey.

2. Plaintiffs are local, hospital-based, emergency medical care providers. As emergency medical care providers, the Plaintiffs are essential workers on the front lines of the pandemic response.

3. Defendant UHG and its more than 1,200 subsidiaries (collectively “United”) comprise the largest health insurer in the United States, reporting \$6.7 billion in profits for the second quarter of 2020, a 97 percent increase from the same period in 2019.<sup>1</sup> United insures 80 million people and controls a large percentage of the commercial healthcare marketplace.

4. For many years, all of the Plaintiffs were parties to Medical Group Participation Agreements (“Participation Agreements”) with defendants UHIC and UHC-NJ, pursuant to which Plaintiffs were contractually obligated to treated patients covered by health insurance plans funded or administered by United (“United Subscribers” or “Subscribers”), and United agreed to pay Plaintiffs agreed-upon rates for the emergency treatment that Plaintiffs provided to United Subscribers.

5. However, in July 2019, United notified each of the Plaintiffs that it was unilaterally terminating the Participation Agreements. These terminations took effect on May 15, 2020.

---

<sup>1</sup> *U.S.’ Largest Health Insurer Reports \$6.7B In Profits Amid COVID, As N.Y. Cuts State Rates*, Newsweek, August 14, 2020, <https://www.newsweek.com/us-largest-health-insurer-reports-67b-profits-amid-covid-ny-cuts-state-rates-1525210> (last visited October 27, 2020).

6. Although Plaintiffs are no longer in United's network, United Subscribers continue to seek treatment at the hospitals staffed by Plaintiffs' physicians. Consistent with their legal duties as emergency department physicians, Plaintiffs provide treatment to all such patients.

7. Because, *inter alia*, United offers its Subscribers coverage for emergent care and because Plaintiffs remain legally obligated to treat United Subscribers in the hospital emergency departments they staff, United has quasi-contractual obligations to reimburse Plaintiffs for the reasonable value of their services, less amounts for which patients are typically held responsible, such as co-payments, co-insurance, and deductible ("Patient Responsibility").

8. Since forcing Plaintiffs out of its network, however, United has dramatically slashed the reimbursements it has paid Plaintiffs for the emergency treatment that Plaintiffs continued to provide United Subscribers, to well below a reasonable amount.

9. Within just the first 45 days after Plaintiffs were forced out of United's network, Plaintiffs' physicians provided emergency department treatment to 1,520 United Subscribers. Of that number, United reimbursed Plaintiffs correctly for only 305 such patients.

10. For the remaining 1,215 United Subscribers treated by Plaintiffs during that 45-day period, United paid Plaintiffs less than \$400,000 on more than \$1.6 million in claims.

11. Even when factoring in Patient Responsibility, Plaintiffs were paid less than 32% of their billed charges on those 1,215 claims.

12. Of those 1,215 underpaid claims during the first 45 days after Plaintiffs left United's network, 197 were for treatment of patients who were suffering from COVID-19. For these 197 claims, Plaintiffs received payments totaling only approximately \$91,000 of their charges totaling more than \$281,000.



13. The underpayments continue to grow on a daily basis because United Subscribers continue to seek treatment in the hospital emergency departments staffed by Plaintiffs' physicians, and United continues to underpay Plaintiffs for that treatment.

14. United's conduct since Plaintiffs were forced out of United's network is in line with United's asserted goal, as expressed to Plaintiffs' representatives in April 2019, of reducing reimbursement payments for the critical emergency treatment that Plaintiffs provide to United Subscribers by 50%.

15. United has partnered with Defendant Multiplan, a so-called "cost management" company, to achieve its goal of dramatically underpaying Plaintiffs.

16. One product that Multiplan offers to United and other commercial payors is "Data iSight." Multiplan represents to the public, healthcare providers, and patients that the Data iSight process is "transparent," "defensible," and "market tested," and results in a "fair price using amounts generally accepted by providers as full payment for services."

17. Citing Data iSight's analysis, United has drastically cut what Plaintiffs customarily received for providing essential medical services.

18. Data iSight's analysis, however, is not what it purports to be. It does not use the local information it purports to, and it exists simply to paper over the naked, unexcused, and illicit greed of United and other commercial payors, whose growth in profit comes at the direct expense of front-line emergency room physicians like Plaintiffs.

19. Through their actions, Defendants have violated multiple common law and statutory obligations to Plaintiffs.

20. As described more fully below, United is liable to Plaintiffs under the doctrine of *Quantum Meruit*, and under New Jersey's statutory prompt pay obligations, based on United's

unabashed failure to reimburse Plaintiffs for anything close to the fair and reasonable value of the service that Plaintiffs have provided to United Subscribers.

21. As also described more fully below, Multiplan is liable to Plaintiffs on their claim for tortious interference with prospective economic advantage, based on Multiplan's false and misleading statements designed to paper over United's failure to pay Plaintiffs for the fair and reasonable value of their services.

22. Moreover, as further described more fully below, all defendants are liable to Plaintiffs under the New Jersey Racketeer Influenced and Corrupt Organizations ("NJ RICO") Act, *N.J.S.A.* 2C:41-2(c) and 2C:41-2(d), based on their conduct of the affairs of a NJ RICO enterprise through a pattern of racketeering activity as defined in *N.J.S.A.* 2C:41-1(d), and their conspiring to do so. This pattern includes multiple acts of racketeering as defined in *N.J.S.A.* 2C:41-1(a)(1), including acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3, theft by deception in violation of *N.J.S.A.* 2C:20-4, and theft of services in violation of *N.J.S.A.* 2C:20-8. This pattern also includes multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of "racketeering activity" under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO's definition of "racketeering activity" under *N.J.S.A.* 2C:41-1(a)(2).

23. By reason of Defendants' conduct, Plaintiffs have been damaged in the amount of at least \$1.1 million, representing the amount by which United has underpaid Plaintiffs for the emergency care that Plaintiffs provided to United Subscribers during just the first 45 days after Plaintiffs were forced out of United's insurance network. This amount increases on a daily basis as Plaintiffs continue to treat United Subscribers. Plaintiffs' damages are subject to trebling on Plaintiffs' NJ RICO claim pursuant to *N.J.S.A.* 2C:41-4(c).

## **PARTIES**

### **A. Plaintiffs**

24. Plaintiffs are physician practice groups who staff emergency departments of hospitals across New Jersey. All of the Plaintiffs maintain administrative offices at 307 South Evergreen Avenue, Woodbury, NJ 08096, in Gloucester County.

25. Plaintiff Atlantic ER Physicians Team Pediatric Associates, PA, is a professional emergency medicine group practice that staffs the emergency department at Kennedy University Hospital Washington Township Campus, 435 Hurffville Cross Keys Road, Turnersville, NJ 08012. It conducts business in Gloucester County, New Jersey.

26. Plaintiff Emergency Care Services of NJ, PA, is a professional emergency medicine group practice that staffs the emergency departments at Inspira Medical Center Mullica Hill, located at 700 Mullica Hill Road, Mullica Hill, NJ 08602; and Inspira Medical Center Woodbury, located at 509 North Broad Street, Woodbury, NJ 08096. It conducts business in Gloucester County, New Jersey.

27. Plaintiff Emergency Physician Associates of North Jersey, PC, is a professional emergency medicine group practice that staffs the emergency departments at Chilton Memorial Hospital, 97 West Parkway, Pompton Plains, NJ 07444; Raritan Bay Medical Center, One Hospital Plaza, Old Bridge, NJ 08857; Raritan Bay Medical Center, 530 New Brunswick Avenue, Perth Amboy, NJ 08861; Overlook Medical Center, 99 Beauvoir Avenue at Sylvan Road, Summit, NJ 07901; Riverview Medical Center, 1 Riverview Plaza, Red Bank, NJ 07701; and East Orange General Hospital, East Orange, NJ 07018. It conducts business in the following New Jersey Counties: Essex, Morris, Middlesex, Monmouth, and Union.

28. Plaintiff Emergency Physician Associates of South Jersey, PC, is a professional emergency medicine group practice that staffs the emergency departments at Virtua Willingboro

Hospital, 218 A. Sunset Road, Willingboro, NJ 08046; Jefferson Cherry Hill Hospital, 2201 Chapel Ave and Cooper Landing Road, Cherry Hill, NJ 08002; Jefferson Stratford Hospital, 18 E. Laurel Road, Stratford, NJ 08084; Jefferson Washington Township Hospital, 435 Hurfville-Cross Keys, Turnersville, NJ 08012-2453; Virtua Memorial--Berlin, 100 Townsend Road, Berlin, NJ 08009; Virtua Memorial--Marlton, 90 Brick Road, Marlton, NJ 08053; Virtua Memorial, Camden, 100 Atlantic Avenue, Camden, NJ 08104; Virtua Memorial, Voorhees, 100 Bowman, Voorhees, NJ 08104; Emergency Care Services of New Jersey, P.A., 509 N. Broad Street, Woodbury, NJ 08096. It conducts business in the following New Jersey Counties: Burlington, Camden, and Gloucester.

29. Plaintiff Emergency Physician Services of New Jersey, PA, is a professional emergency medicine group practice that staffs the emergency departments at Holy Name Medical Center, 718 Teaneck Road, Teaneck, NJ 07666; Penn Medicine Princeton Health, 1 Plainsboro Road, Plainsboro, NJ 08536; and Virtua Memorial Hospital, 175 Madison Avenue, Mount Holly, NJ 08060. It conducts business in the following New Jersey Counties: Bergen, Middlesex, and Burlington.

30. Plaintiff Middlesex Emergency Physicians, PA, is a professional emergency medicine group practice that staffs the emergency department at Hackensack JFK Medical Center, 65 James Street, Edison, NJ 08820. It conducts business in Middlesex County, New Jersey.

31. Plaintiff Plainfield Emergency Physicians, PA, is a professional emergency medicine group practice that staffs the emergency departments at Muhlenberg Regional Medical Center, 1200 Park Avenue, Plainfield, NJ 07061. It conducts business in Union County, New Jersey.

**B. Defendants and the NJ RICO Enterprises**

32. Defendant UHG is a corporation organized under the laws of the State of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343. UHG is the parent of numerous, wholly-owned subsidiaries. These wholly-owned subsidiaries act in concert and under common control to maximize profits for UHG's shareholders.

33. One such subsidiary is Defendant UHIC, a corporation organized under the laws of the State of Connecticut, with its principal place of business located in Hartford, Connecticut.

34. Another such subsidiary is Defendant UHC-NJ, a corporation organized under the laws of the State of New Jersey, with its principal place of business located in Fairfield, New Jersey.

35. Defendant Multiplan is a New York corporation with its principal place of business at 115 Fifth Avenue, New York, NY 10003. Multiplan develops and operates healthcare provider networks and offers related cost management products to insurance companies and other payers of health benefits. As noted above, one such product is Data iSight, which Multiplan offers to United and other payers.

36. United and Multiplan (collectively, "the United-Multiplan Enterprise" or "Enterprise") constitute a NJ RICO "enterprise" within the meaning of *N.J.S.A. 2C:41-(c)*. The United-Multiplan enterprise is an ongoing association of legal entities "associated in fact although not a legal entity" under *N.J.S.A. 2C:41-(c)*.

37. The United-Multiplan Enterprise is an ongoing informal organization, engaged in and the activities of which affect trade or commerce, with the common purpose of engaging in a course of conduct.

38. The United-Multiplan Enterprise has as a purpose engaging in and attempting to engage in incidents of racketeering activity intended to unlawfully reduce the amounts paid to Plaintiffs and other out of network providers of medical services.

39. There are relationships among the entities that form the Enterprise.

40. Specifically, the United entities have relationships with Multiplan. The United entities have contracts with Multiplan, coordinate their efforts with Multiplan, and share with Multiplan money obtained from Plaintiffs and other victims of the scheme.

41. The relationships between the members of the association-in-fact enterprise known as the United-Multiplan Enterprise are sufficient to permit them to pursue the enterprise's purpose. The United entities cooperate closely with Multiplan to implement the scheme and share the benefits of the scheme with Multiplan. These relationships continue to the present as the United-Multiplan Enterprise continues to pursue its purpose.

42. The Enterprise furnishes the vehicle through which the acts of racketeering activity are committed.

43. The Enterprise functions as a continuing unit.

44. Each of the Defendants participates purposefully and knowingly in the affairs of the United-Multiplan Enterprise by engaging in activities that seek to further, assist or help effectuate the goals of the enterprise.

45. Each of the Defendants agreed to participate in the affairs of the Enterprise with knowledge of the Enterprise's unlawful goals and purposes, including the scheme, to commit acts in furtherance of the Enterprise's common purpose, and to share in monies obtained through the scheme.

46. Each of the Defendants has engaged and continues to engage in incidents of racketeering activity in furtherance of the Enterprise's common unlawful purpose.

47. Defendants agreed to, and do act through the Enterprise to, manipulate reimbursement rates and control allowed payments to the Physicians.

48. As detailed more fully below, each of the named defendants has participated, directly or indirectly, in the affairs of themselves, the other named defendants, and the United-Multiplan Enterprise through a pattern of racketeering as defined in *N.J.S.A. 2C:41-1(a)(1)* and (2). This pattern includes multiple acts of theft by unlawful taking in violation of *N.J.S.A. 2C:20-3*, theft by deception in violation of *N.J.S.A. 2C:20-4*, theft of services in violation of *N.J.S.A. 2C:20-8*, and mail and wire fraud in violation of 18 U.S.C. § 1341 and 1343, which are included among predicate acts of "racketeering activity" under *N.J.S.A. 2C:41-1(a)(2)*.

### **JURISDICTION AND VENUE**

49. Venue is proper in this Court pursuant to *R. 4:3-2(a)* because all of the Plaintiffs maintain administrative offices in Gloucester County, and some of the plaintiffs in this action --- including Plaintiff Atlantic ER Physicians Team Pediatric Associates, PA, Plaintiff Emergency Care Services of NJ, PA, and Emergency Physician Associates of South Jersey, PC -- staff the emergency departments of hospitals located within Gloucester County, New Jersey. Thus, all plaintiffs actually do business in Gloucester County and, therefore, are deemed to reside in Gloucester County under *R. 4:3-2(b)*.

50. This Court has personal jurisdiction over all of the Defendants in this action because all of the Defendants have sufficient minimum contacts with the State of New Jersey and, as alleged below: (i) the Defendants are found in, have agents in, and/or transact their business and affairs in New Jersey; (ii) a substantial part of the events or omissions giving rise to the claims for

relief occurred in New Jersey; (iii) the ends of justice require that those of the Defendants residing outside New Jersey be brought before the Court to answer for their conduct engaged in and directed toward this State; and (iv) one of the objects of Defendants' conspiracy was to injure Plaintiffs in New Jersey, and all Defendants were aware of this object.

## **STATEMENT OF FACTS**

### **A. Background**

51. Plaintiffs provide life-saving emergency care to thousands of residents throughout the State of New Jersey.

52. The claims at issue in this action are for services Plaintiffs rendered to patients insured by commercial insurance plans sold and/or administered by United, including plans purchased from the healthcare exchanges, since Plaintiffs exited United's network on May 15, 2020.<sup>2</sup>

53. The underpaid claims at issue do not relate to or involve any government sponsored products, such as Medicare Advantage and managed Medicaid.

54. As providers of emergency medical services, Plaintiffs do not and cannot verify a patient's insurance benefits and obtain authorization for treatment from insurance companies prior to rendering treatment.

55. This is due to the practical impossibility of obtaining insurance eligibility information or insurance pre-certification in emergency medical situations and the legal requirements imposed upon emergency medical professionals.

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<sup>2</sup> Healthcare Exchanges refers to those exchanges established by the Affordable Care Act ("ACA") and may be operated by either the federal or state government. New Jersey operates its own ACA exchange. See <https://nj.gov/getcoverednj> (last visited October 27, 2020).



56. Healthcare providers are either “in-network” or “out-of-network” with respect to a particular insurance carrier. “In-network” or “participating” providers are those who contract with a health insurer that requires them to accept discounted negotiated rates as payment in full for covered services.

57. “Out-of-network” or “non-participating” providers are those that do not have contracts with an insurance carrier to accept discounted rates and instead set their own fees for services based on a percentage of charges.

58. From November 1, 2008, until May 15, 2020, Plaintiffs were “in-network,” or “participating” providers with United. This meant that Plaintiffs were contractually obligated to treat patients covered by health insurance plans funded or administered by United (“United Subscribers” or “Subscribers”), and United agreed to pay Plaintiffs agreed-upon rates for the emergency treatment that Plaintiffs provided to United Subscribers.

59. However, on July 9, 2019, United issued written notices to each of the Plaintiffs informing them that United was unilaterally terminating Plaintiffs’ Participation Agreements with UHIC and UHC-NJ.

60. At the time United issued its termination notices, the parties were within an annual renewal term that was not set to expire until May 15, 2020. Yet, in violation of the contractual termination provisions, United’s termination notices stated that Plaintiffs’ Participation Agreements would terminate effective November 1, 2019, instead of at the conclusion of the contractual renewal term on May 15, 2020.

61. When Plaintiffs brought this clerical mistake to United’s attention, United doubled down and insisted that it had the right to terminate Plaintiffs’ Participation Agreements on November 1, 2019, rather than at the conclusion of the renewal term on May 15, 2020.

63. Pre-termination communications between representatives of Plaintiffs and United explain why United was so anxious to terminate Plaintiffs' Participation Agreements. From late 2017 to 2019, representatives of Plaintiffs attempted to negotiate with United for Plaintiffs to remain contracted, participating, in-network providers with United at sustainable rates, and for other affiliated entities to become contracted, participating, in-network providers with United. These communications occurred over the course of multiple meetings in person, by phone, and by email correspondence. However, United refused to negotiate in good faith.

65. In or around December 2017, Mr. Rosenthal told Plaintiffs' agent that United intended to implement a new benchmark pricing program to reduce out-of-network reimbursements.

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participating claims, and an amount materially less than what United was paying other contracted providers in the same geographic market. United's proposed rate was neither reasonable nor fair.

67. Subsequently, in May 2018, Mr. Rosenthal escalated United's threats to Plaintiffs' agent, making clear during a meeting that, if Plaintiffs' agent did not agree to contract for the drastically reduced rates, United would implement benchmark pricing that would reduce all Plaintiffs' non-participating reimbursement by one-third.

68. On or about November 2, 2018, Plaintiffs' representative spoke with John Haben, VP UnitedHealth Network, Greg Dosedel, VP National Ancillary Contracting for UnitedHealth Network, and Chris Parillo, VP Network Management. In this conversation, United's team focused on their intent to lower the amount that was paid to Plaintiffs and to do so through "benchmark" pricing.

69. On or about December 14, 2018, Plaintiffs' representative was able to speak with Mr. Haben. In this conversation, Plaintiffs' representative continued to press the issue of appropriate payment rates. During this conversation, Mr. Haben did little more than reiterate that United would utilize benchmark pricing software to achieve lower rates. United did exactly that. As Mr. Haben told Plaintiffs' representative during this meeting, it was not his problem to determine appropriate market rates of payment; instead, it was his problem to stop Multiplan from paying 90% of Plaintiffs' billed charges.

70. Despite having announced their intent to slash reimbursement rates to Plaintiffs' agent, and even stating the amount by which rates would be reduced, United and Multiplan continue to represent to Plaintiffs, other providers, and the public that the reimbursement rates paid for out-of-network emergency services reflect the rates paid by similar payers in the same geographic region. As set forth in detail in the following sections, these representations were false.

71. On or about April 18, 2019, Plaintiffs' representative spoke with Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare and other senior management from United. United's team responded that payments would continue to decrease and would be paid at 250% of Medicare rates beginning in 2020. When asked why United was forcing such dramatic cuts on out-of-network reimbursements, Mr. Schumacher said it was simply "because we can."

72. Continuing the scheme, on July 7, 2019, Mr. Schumacher advised in a phone call to Plaintiffs' agent that United over three years planned to cut every Plaintiffs' rates to just 42% of the average and reasonable rate of reimbursement that Plaintiffs had received in 2018.

73. Mr. Schumacher additionally advised that United leadership was aware of and supported the drastic cuts, while providing no objective basis for them.

74. The next day, July 8, 2019, United's representative Angie Nierman, a Vice President of Networks at Defendant UnitedHealth Group, Inc., sent via interstate wires a written proposal to Plaintiffs' agent reflecting Mr. Schumacher's stated cuts.

75. In addition to denying Plaintiffs what is owed to them for the claims at issue in this litigation, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

76. This scheme is consistent with statements made to Plaintiffs' representative by Multiplan executives Bruce Singleton, SVP Network and Development Strategy, and Michael McEttrick, VP Healthcare Economics, in a discussion on July 11, 2019, just two days after United notified Plaintiffs that it was terminating Plaintiffs' Participation Agreements. Plaintiffs' representative was told that Data iSight looks at "a lot" of claims to derive a median accepted charge amount. They would not provide any further transparency or specifics into how the amount

was determined. Neither Singleton nor McEttrick would state what data sources were used to derive the payment amounts.

77. Singleton and McEttrick acknowledged that payers such as United could affect pricing and then quickly backtracked, asserting the supposed independence of the Data iSight product. Overall, the conversation clearly pointed to the conspiracy between United and Multiplan to “fix” pricing outcomes and underpay out-of-network emergency providers such as Plaintiffs.

**C. Since United Terminated Plaintiffs’ Participation Agreements, United Subscribers Have Continued to Seek and Obtain Emergency Medical Treatment from Plaintiffs’ Physicians**

78. As noted above, United’s termination of Plaintiffs’ Participation Agreements took effect on May 15, 2020. Since then, Plaintiffs have been out-of-network with United.

79. Although Plaintiffs are now out-of-network with respect to United, United Subscribers continue to receive treatment from Plaintiffs’ physicians at the hospital emergency departments they staff. Importantly, federal and New Jersey law obligate Plaintiffs, as emergency medical providers, to provide treatment to all patients who present at emergency departments. 42 U.S.C. § 1395dd; *N.J.S.A.* 26:2H-18.64.

80. Among other things, the federal Emergency Medical Treatment and Labor Act (“EMTALA”), and similar provisions of New Jersey laws and regulations, mandate that hospitals and the physicians that staff hospital emergency departments have a duty to provide an appropriate medical screening examination to all individuals who come to an emergency department with what they believe to be an emergent or urgent condition. 42 U.S.C. § 1395dd(a); *N.J.S.A.* 26:2H-18.64; *N.J.A.C.* 8:43G-12.7(c).

81. If it is determined that an emergency medical condition exists, the patient must be evaluated by a physician and, with certain limited exceptions, provided such medical treatment as

is necessary to assure that the condition has been stabilized. 42 U.S.C. § 1395dd(b), (c); *N.J.A.C.* 8:43G-12.7(d), (e).

82. If it is determined that an emergency does not exist, the patient shall either be treated in the emergency department or referred to an appropriate health care provider, and be given appropriate discharge instructions. *N.J.A.C.* 8:43G-12.7(f), (n).

83. Importantly, New Jersey regulations make clear that no patient who comes to a hospital emergency department shall be discharged to home or another facility without being seen and evaluated by qualified medical personnel, which must occur within four hours of the patient's coming to the emergency department. *N.J.A.C.* 8:43G-12.7(g).

84. EMTALA and New Jersey law subject emergency department physicians to civil liability for violations. For example, "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital" who negligently violates EMTALA is subject to civil monetary penalties of up to \$50,000 per violation. 42 U.S.C. § 1395dd(d)(1)(B).

85. There are no exceptions to the emergency medicine providers' legal obligation to render services based on a patient's ability to pay or the presence of health insurance. Notably, *N.J.S.A.* 26:2H-18.64 provides that "[n]o hospital shall deny any admission or appropriate services to a patient on the basis of that patient's ability to pay or source of payment." A patient's ability to pay in no way affects or impedes the delivery of emergency care by Plaintiffs or the hospitals they staff.

**D. With Plaintiffs' Duty to Treat United Subscribers Comes United's Concomitant Duty to Pay Plaintiffs a Reasonable Rate for Out-of-Network Emergency Services**

86. Because emergency medical providers have no discretion to turn patients away, and must treat all patients, regardless of ability to pay, they depend on commercial insurance

companies to meet their legal responsibility and timely and properly pay a reasonable rate to providers such as Plaintiffs who are not “in-network” and are not “participating” providers.

87. The duty of healthcare insurers to pay a reasonable rate to out-of-network providers for the treatment they are required to provide to those insurers’ subscribers derives not only from principles of fundamental fairness and equity, but also from multiple sources of state and federal law.

### **1. New Jersey’s Prompt Payment Requirements**

88. For example, in processing United’s claims, United is governed by the prompt payment requirements of the New Jersey Health Claims Authorization, Processing and Payment Act (“HCAPPA”).

89. HCAPPA’s requirements are codified in various sections of the New Jersey Statutes, including, as applicable to United, *N.J.S.A. 17B:26-9.1* (applicable to health insurance other than group and blanket insurance), *N.J.S.A. 17B:27-44.2* (applicable to group health and blanket insurance), and *N.J.S.A. 26:2J-8.1(d)(9)* (applicable to health maintenance organizations). Regardless of the nature of the payor and type of insurance, however, HCAPPA’s prompt payment requirements are the same.

90. Under HCAPPA, the insurance carrier must acknowledge receipt of all claims, both emergent and non-emergent, within two working days. *See N.J.S.A. 17B:26-9.1(d)(5); N.J.S.A. 17B:27-44.2(d)(5) and N.J.S.A. 26:2J-8.1(d)(5).*

91. HCAPPA further requires insurance carriers to pay claims within 30 days after the insurance carrier receives the claim when submitted electronically, or 40 days if received non-electronically, provided the following conditions apply:

- (a) the healthcare provider is eligible at the date of service;

(b) the person who receives the healthcare service is covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that is distributed in advance to the healthcare provider or covered person in accordance with the provisions of section 4 of P.L.2005, c. 352 (C.17B:30-51); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

*N.J.S.A. 17B:26-9.1(d)(1), 17B:27-44.2(d)(1) and N.J.S.A. 26:2J-8.1(d)(1).*

92. In addition, HCAPPA requires that, if all or a portion of the claim is not paid within the statutory timeframe for one or more statutorily enumerated reasons, the payer shall notify the health care provider and covered person in writing within 30 days of receipt of an electronic claim, or within 40 days of receipt of a claim submitted by other than electronic means, that: (i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim; (ii) the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim; (iii) the payer disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or (iv) the payer finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor. *N.J.S.A. 17B:26-9.1(d)(2); N.J.S.A. 17B:27-44.2(d)(2).*

93. Moreover, under HCAPPA, an insurance carrier's dispute of a portion of the claim does not excuse the carrier from payment of the entire claim: "Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance



with the time limit established in paragraph (1) of this subsection.” *N.J.S.A. 17B:26-9.1(d)(4)*, *N.J.S.A. 17B:27-44.2(d)(4)* and *N.J.S.A. 26:2J-8.1(d)(4)*.

## **2. New Jersey’s Emergency Coverage Mandates**

94. New Jersey regulations also mandate that insurance carriers determine coverage promptly and pay promptly to ensure patient access to emergency care regardless of the patient’s type of insurance coverage. Under this regulatory regime, New Jersey law requires healthcare insurers to notify their subscribers that they are entitled to have “access” and “payment of appropriate benefits” for emergency conditions on a “24 hours a day,” “seven days a week” basis. *N.J.A.C. 11:24A-2.5(b)(2)*.

95. Further, under New Jersey law prior to August 30, 2018, for the emergency/urgent treatment provided by Plaintiffs to United Subscribers, insurers who provided coverage for emergency/urgent care and receive a claim for emergency/urgent care provided by an out-of-network hospital were required to pay an amount sufficient to protect the patient/insured from being balance billed. To meet this obligation, insurers could (a) pay the full amount of the charges, (b) negotiate a settlement of the claim with the provider, or (c) negotiate an in-network agreement with the provider. *Aetna Health, Inc. v. Srinivasan*, 2016 N.J. Super. Unpub. LEXIS 1515 (App. Div., June 29, 2016).

## **3. The OON Act Modifies New Jersey’s Emergency Coverage Mandate, but Retains the Obligation for Insurers to Pay a Reasonable Rate**

96. The New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (“OON Act”), codified at *N.J.S.A. 26:2SS-1 to -20*, modified HCAPPA’s prompt payment requirements for inadvertent or emergency claims upon taking effect on August 30, 2018. The OON Act applies to all health insurance plans in New Jersey other than

self-funded plans governed by the federal Employee Retirement Income Security Act that have not opted into the law's coverage.

97. Specifically, under the OON Act, for inadvertent or emergency out-of-network payments, the insurer must make a determination within 20 days from the date of receipt of a claim for services whether it considers the claim to be excessive. *N.J.S.A. 26:2SS-9(c)*. If not, the insurer must promptly pay the claim. If the insurer considers the claim to be excessive, it must notify the provider of this determination within 20 days of receipt of the claim. If the insurer provides this notification, the insurer and the provider have 30 days from the date of notification to negotiate a settlement. The insurer may attempt to negotiate a final reimbursement amount with the out-of-network healthcare provider, which differs from the amount paid by the insurer pursuant to the requirements under *N.J.S.A. 26:2SS-9*.

98. If no settlement is reached after 30 days, the insurer must pay the provider the insurer's final offer for the services. If the insurer and provider cannot agree on the final offer as a reimbursement rate for these services, the insurer, provider, or patient beneficiary, as applicable, may initiate binding arbitration within 30 days of the final offer, pursuant to *N.J.S.A. 26:2SS-10*.

99. Binding arbitration under the OON Act is permissive, not mandatory, for claims subject to the OON Act. *N.J.S.A. 26:2SS-7* ("If a covered person receives medically necessary services at an out-of-network health care facility on an emergency or urgent basis as defined by [EMTALA and *N.J.S.A. 26:2H-18.64*]), and the carrier and facility cannot agree on the final offer as a reimbursement rate for these services pursuant to section 9 of this act, the carrier, health care facility, or covered person, as applicable, *may* initiate binding arbitration pursuant to section 10 or 11 of this act") (emphasis added).

100. The OON Act does not dispense with the requirement that insurers pay providers a reasonable amount for the services covered under the OON Act. It just impacts who determines the reasonable rate. For claims subject to the OON Act that are arbitrated, the arbitrator determines the appropriate amount payable. *N.J.S.A. 26:2SS-10*. For claims that are not subject to the OON Act (such as claims where the United Subscriber is covered by a self-funded ERISA Plan), or claims for which arbitration has not been requested, healthcare providers may seek to enforce common law remedies to recover the reasonable value of their services from insurers. *See The Plastic Surgery Center, P.A. v. Aetna Life Ins. Co.*, No. 18-3381, 18-3356, 2020 WL 4033125 (3d Cir. July 17, 2020) (holding that plaintiff out-of-network health care provider could pursue state common law claims for breach of contract and promissory estoppel claims independent of ERISA, as they sought to enforce obligations independent of an ERISA plan); *Srinivasan*, 2016 N.J. Super. Unpub. LEXIS 1515 (App. Div., June 29, 2016) (upholding \$2.1 million judgment in favor of out-of-network provider against health insurer on unjust enrichment claim).

101. New Jersey law also provides interest as a penalty against insurers such as United for overdue payments in the amount of 12% per annum, *N.J.S.A. 17B:26-9.1(d)(9)*, *N.J.S.A. 17B:27-44.2(d)(9)* and *N.J.S.A. 26:2J-8.1(d)(9)*, except during the pendency of arbitration under the OON Act, to the extent that the OON Act applies, *see N.J.S.A. 26:2SS-10(c)(2)*. The interest must be paid to the healthcare provider at the time the overdue payment is made. *N.J.S.A. 17B:27-44.2(d)(9)* and *N.J.S.A. 26:2J-8.1(d)(9)*.

#### **4. Federal Coverage and Payment Mandates**

102. The duty of health insurers such as United to pay out-of-network providers a reasonable rate for emergency care is also embodied in federal coverage and payment mandates. For example, the Patient Protection and Affordable Care Act (“ACA”) requires health insurers

such as United to reimburse out-of-network providers for emergency services at a sufficiently high level to ensure that their Subscribers’ cost-sharing does not exceed what the Subscribers’ cost-sharing would have been had they obtained the emergency services at an in-network facility. 42 U.S.C. § 300gg-19a(b)(1). For out-of-network emergent claims, United must ensure that it pays at least the greatest of three amounts specified in 29 C.F.R. § 2590.715- 2719A(b)(3)(i)(A)-(C). One of these is the amount for the emergency service calculated using the method the plan generally uses to determine payments for out-of-network services (such as usual, customary and reasonable charges), but substituting in-network cost-sharing provisions. (*See id.*).

103. Moreover, the Families First Coronavirus Response Act (“FFCRA”) was enacted on March 18, 2020. Pub. L. No. 116-127 (2020). Section 6001 of the FFCRA generally requires group health plans and health insurers such as United that offer group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection and diagnosis of COVID-19, when those items or services are furnished on or after March 18, 2020, and during the applicable period of the federal COVID-19 public health emergency declaration.<sup>3</sup> Under the FFCRA, plans and health insurers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

104. Additionally, the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”) was enacted on March 27, 2020. Pub. L. No. 116-136 (2020). Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic

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<sup>3</sup> The Secretary of Health and Human Services has recently extended the public health emergency period under the FFCRA through January 31, 2021. *See* <https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-20Oct2020.aspx> (last visited October 27, 2020).

items and services that plans and health insurers such as United must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, Section 3202 of the CARES Act generally requires plans and health insurers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the provider's published billed charges.

105. United's own website purports to comply with the FFCRA and CARES Act mandates by stating, "[t]o help you access the COVID-19 treatment you need, UnitedHealthcare is extending cost-share waivers for our Individual, Fully-Insured Group Market and Medicare Advantage health plans, as noted below," and that for individually and fully-insured group health plans, "[y]ou will have \$0 cost-share (copay, coinsurance and deductible) for network visits, including a telehealth visit, for COVID-19 treatment through Dec. 31, 2020. Out-of-network cost-share waivers will end Oct. 22, 2020."<sup>4</sup>

**E. Instead of Paying Out-of-Network Providers Reasonable Rates, United Conspires with Multiplan to Fabricate Artificially Low Rates**

106. Instead of paying out-of-network health care providers reasonable rates, United has conspired with Multiplan to fabricate artificially low rates.

**1. Background: The Ingenix Precursor**

107. The enterprise formed between United and Multiplan seeks to reproduce a scheme involving a fraudulent database created and operated by a wholly-owned United subsidiary formerly known as "Ingenix." (Ingenix is now called "Optum.")

108. The Ingenix scheme led United to pay \$400 million in settlements in 2009.

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<sup>4</sup> See <https://www.uhc.com/health-and-wellness/health-topics/covid-19/coverage-and-resources> (last visited October 27, 2020).

109. Similarly, with regard to the claims mentioned in this filing, instead of using their own fraudulent databases as was done with Ingenix, United has employed Multiplan and Data iSight to play the role of Ingenix and in so doing has created a NJ RICO enterprise.

110. An investigation into Ingenix by then New York Attorney General Andrew Cuomo “uncovered a fraudulent and conflict-of-interest ridden payment system affecting millions of patients and their families and costing Americans hundreds of millions of dollars in unexpected and unjust medical costs.”<sup>5</sup>

111. In 2009, United paid \$400 million to settle cases arising from this misconduct. Three hundred fifty million dollars was paid to settle a class action against those entities. Another fifty million was paid for the establishment of the FAIR Health database and website. The settlement agreement dictated that “United shall use [FAIR Health] as the basis for determining Allowed Amounts for Covered Out-Of-Network Services or Supplies.” The Settlement Agreement stated the standard “usual, customary, and reasonable” (“UCR”) reimbursement rates were equivalent to “reasonable and customary,” “average,” or “prevailing” *charges* submitted by healthcare providers.

112. Also in 2009, the Office of the Attorney General for the State of New York announced the results of its investigation into Ingenix in a landmark agreement entitled “Assurance of Discontinuance Under Executive Law § 63(15)” (“Assurance Order”). According to the Assurance Order, the payment rates compiled by Ingenix were based on a “conflict of interest.” The attorney general concluded that the system “meant to reimburse consumers fairly as a

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<sup>5</sup> *Attorney General Cuomo Announces Historic Nationwide Reform Of Consumer Reimbursement System For Out-Of-Network Health Care Charges*, NY AG Press Release, October 27, 2009. <https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer> (last visited October 27, 2020).

reflection of the market is instead wholly owned and operated by the [insurance] industry” who have an “incentive to manipulate the data they submit to Ingenix so as to depress payment rates they determine using the Ingenix schedules, given their own payment obligations toward consumers.”

113. The prices generated by Ingenix were inadequate because: 1) Ingenix did not audit the data provided by insurers to make sure that the charges properly reflect what providers actually charged in the marketplace; 2) Ingenix used statistically invalid “edits” to exclude a disproportionate amount of high charges from its UCR calculations; and 3) Ingenix “lumped” charges for the same service together regardless of whether the service was provided by a certified specialist with many years of experience or a less experienced provider such that the aggregate UCR rate calculated by the database was artificially low.

114. Although this matter did not ultimately go to a jury, the allegations clearly show that this conduct was fraudulent.

115. The fraud alleged in this case is even worse because the data that Multiplan uses here to price the claims of out of network providers is even further removed from true UCR rates than it was in Ingenix.

116. The Assurance Order required the insurance industry cease using the Ingenix database and create a “new, independent database, not controlled by any insurer, to be used for determining fair and accurate reimbursement rates.” The Assurance Order also established a “Healthcare Information Transparency Website” to inform and educate the public about reimbursement rates.

117. This “new” database was funded by UnitedHealth Group (\$50 million), Aetna (\$20 million), Wellpoint (\$10 million), CIGNA (\$10 million), MVP Health Care Inc. (\$535,000),

Independent Health (\$475,000), and HealthNow (\$212,500). Out of this settlement, the independent not-for-profit entity “FAIR Health, Inc.” (which stands for “Fair and Independent Research”) was created.

118. When the settlement was announced, Thomas L. Strickland, then the Executive Vice President and Chief Legal Officer of UnitedHealth Group, stated: “We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy...We are pleased that a not-for-profit entity will play this important role for the marketplace.”<sup>6</sup> United’s subsequent conduct belies this statement.

119. As a result of the bad press surrounding the Ingenix name, United changed Ingenix’s name to “Optum” in 2010.

120. Unfortunately for healthcare providers, United’s legal obligations under the Assurance Agreement to utilize FAIR Health and pay out-of-network claims at a fair rate predicated upon UCR terminated five years after the creation of FAIR Health, in or about 2015.

121. Not long after the termination of its obligations under the Assurance Agreement, free from its terms and without a court order requiring it pay out-of-network healthcare providers using a UCR rate, United sought out the services of a third party, Multiplan, to repeat the same fraud.

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<sup>6</sup> Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars, NY OAG Press Release January 13, 2009, <https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends> (last visited October 27, 2020).



**2. The Defendants form the United-Multiplan Enterprise to Fraudulently Avoid Paying “Reasonable” Payments**

122. Defendants, United and Multiplan have formed an ongoing informal organization, with the common purpose of engaging in a course of conduct that includes the development and implementation of a scheme to fraudulently underpay out-of-network emergency medical services.

123. Defendants associated with one another to assert a false and fraudulent methodology applied to a fraudulently manipulated database as an excuse for under-reimbursing Plaintiffs for services provided, to the Defendants’ financial benefit.

124. An association does not stop becoming an association because the relationship between its insureds are documented in a contract, nor does anything in the definition of enterprise insulate from liability those whose common purpose may include some legal activity. NJ RICO’s definition of enterprise expressly “includes illicit as well as licit enterprises.” *N.J.S.A. 2C:41-1(c)*.

125. The enterprise formed by United and Multiplan is the vehicle for the illegal, racketeering activity of theft by unlawful taking, theft by deception, theft of services, and mail and wire fraud, as discussed more fully below.

126. The Defendants share a common purpose in performing these activities, which includes financial gain as the direct result of the fraudulent scheme.

127. The Defendants worked together to develop the false and fraudulent reimbursement rates that were provided to Plaintiffs and other emergency medical providers.

128. This is clearly set forth in “Whitepapers” described in the following sections. The Whitepapers provided the roadmap that United and Multiplan jointly developed to achieve specific, fraudulent payment rates.

129. United exercised control over the Enterprise by setting “target prices” for Multiplan to beat, and by determining the method and “routing” that would be used by Multiplan to arrive at

the underpayment amount. United also sent the eventual payment to the provider along with written misrepresentations regarding the payment.

130. Multiplan exercised control over the Enterprise by designing and implementing Data iSight to achieve the low payment rates under the target price determined by United, without regard to UCR rates using purposefully faulty data that Multiplan had purchased.

131. For all of the claims, United compensates Multiplan based on the underpayment of claims.

132. Plaintiffs and providers have a property interest in their accounts receivable related to the payment of claims for their professional services.

133. Underpayment of the claims through fraudulent means deprives Plaintiffs and providers of their property. United and Multiplan both profit from this fraud.

134. United profits by fraudulently retaining money that properly belongs to Plaintiffs for the services that Plaintiffs' physicians provided to United Subscribers..

135. Multiplan profits when United shares with it the money obtained by implementing the fraudulent Data iSight process.

136. Multiplan's implementation of Data iSight to further the fraudulent scheme and further the purpose of the enterprise shows Multiplan's management over and participation in the enterprise.

137. Further, there are relationships among the entities associated with the enterprise.

138. United contracts with Multiplan to create the false impression of legitimacy to their activities.

139. United and Multiplan coordinate their efforts in undertaking the racketeering activities.

140. United and Multiplan share the money obtained from Plaintiffs and other victims of the scheme.

141. The relationships between United and Multiplan are sufficient to permit them to pursue the enterprise's purpose.

142. These relationships continue to the present time and the enterprise continues to pursue its purpose. The enterprise functions as a continuing unit.

### **3. The FAIR Health Database**

143. The creation of the FAIR Health database was intended to provide a reasonable methodology for determining reimbursements to out-of-network health care providers, including Plaintiffs. Indeed, then New York Attorney General Andrew Cuomo stated that he believed that the FAIR Health database would solve the inherent conflicts of interest that plagued the Ingenix databases.

144. The FAIR Health database claims “to provide reliable information about healthcare costs because each year health insurers around the country send [it] over a billion healthcare bills, which are added to FAIR Health's database of more than 31 billion claims,” and that FAIR Health uses “information from those claims to estimate what providers charge, and what insurers pay, for providing healthcare to patients.”<sup>7</sup> No providers submit pricing information; only insurers do so. Many states use the FAIR Health database as a guidepost for healthcare consumer protection.

145. Moreover, Maximus, the arbitration contractor engaged by the New Jersey Department of Banking and Insurance to decide payor-provider arbitrations under the OON Act,

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<sup>7</sup> FAIR Health Consumer, “About FAIR Health,” accessed at <https://www.fairhealthconsumer.org/#about> (last visited October 27, 2020).





159. In fact, Data iSight’s calculations are not completely or even partially transparent; rather, they are deliberately opaque. Data iSight is a complex product implemented by a software engine that is designed to cull the lowest possible number from a flawed, proprietary database of healthcare claims data that is wholly unrepresentative of amounts actually charged by or paid to similar medical providers in Plaintiffs’ surrounding area.

<sup>10</sup> [https://www.multiplan.com/payers/resourcecenter/salescenter/pdfs/MKT5105\\_Data\\_iSight.pdf](https://www.multiplan.com/payers/resourcecenter/salescenter/pdfs/MKT5105_Data_iSight.pdf)  
(last visited October 27, 2020).

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### (a) Overview

162. Instead of looking at the actual insurance benefits or the law to determine how much to pay for a claim, and despite having billions of lines of claim data and years of claims history to reference, a database of payment information it paid to create, and its own in-house data analytics company, United enlisted the help of Multiplan.

164. Instead of using the FAIR Health Database or its own internal data, United used Multiplan to determine payment rates. The lower the rate that Multiplan produced, the more money Multiplan was paid.

166. Multiplan offered a menu of pricing tools that it knew would be used to derive different payment rates for the same quoted insurance term, *i.e.* “amounts charged for services by similar providers in a similar geographic area.”

167. Multiplan offered three general categories of services to United: 1) United could rent access to Multiplan's contracts with providers through "rental-network" agreements; 2) United could have Multiplan negotiate individual claims on behalf of United for individual agreements with providers for payment; or 3) United and Multiplan could use Data iSight to calculate payment rates.

168. For the underpaid claims described in Part F, *infra*, United and Multiplan agreed to use Data iSight instead of Multiplan's negotiations or rental network services.

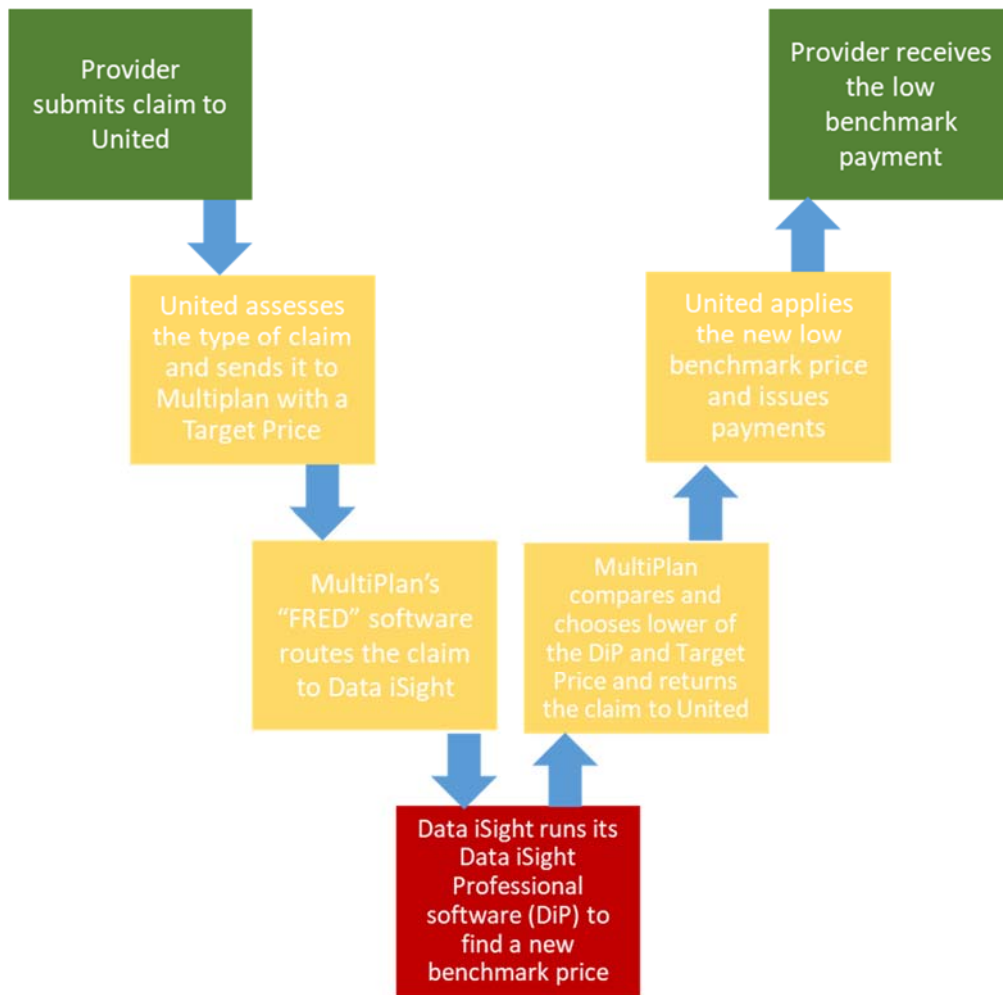
169. United deliberately avoided using Multiplan's other "legitimate" products because those services priced claims at higher rates than United wanted to pay. United chose to use Data iSight pricing because it knew, based on Multiplan's marketing and on meetings between United and Data iSight, that payment rates would be artificially low.

170. Multiplan Inc. offers a host of mechanisms for "cost-containment." Multiplan has an internal "Claims Savings" search engine, known within the company as "FRED."

171. FRED takes inputs from the claims United forwards it, and routes them to the respective repricing tool, runs the respective tool, and produces an output.

172. Data iSight can be generally summarized by the following flowchart:





173. In general, Data iSight derives a rate, then compares the rate to the “benchmark” or Target Price selected by United, where United sends one. If the Data iSight rate is lower than the Target Price and the provider’s billed charges, then the Data iSight rate is used to pay claims.

174. The pricing process starts with United forwarding a claim to Multiplan. At its sole discretion, United chooses which claims to price internally, which claims to send for one of Multiplan’s other pricing products, and which claims to price through Data iSight.

175. United sends claim information to Multiplan electronically via a software “electronic data interchange” program (hereinafter “EDI”). The EDI process allows United to communicate several critical inputs to Multiplan: (A) Claims Information (Policy Type, Charge

Amount, Billing Codes); (B) Routing to Designated Repricing Tool (*i.e.*, whether to route the claim to Data iSight or to other Multiplan pricing products such as “Negotiations” or “Rental Networks”; (C) the Benchmark “Target Price” for the claim (*i.e.*, the benchmark price that determined Multiplan’s compensation); or (D) the percentile of Data iSight’s proprietary database to use to set a benchmark rate.

176. Once Multiplan receives information from United, it routes the information through its “FRED” search engine, which in turn routes the claim to Data iSight.

177. The most commonly used and pernicious repricing method utilized by Data iSight, “DiP,” is discussed below.

178. Significantly, the FRED system has FAIR Health usual and customary data loaded into it, available at the click of a mouse, but Multiplan and United consciously choose not to use it.

#### **(b) DiP: The Data iSight Software Engine**

179. Upon receipt of the data, Data iSight deploys its proprietary claims repricing method. The method first classifies and sorts claims information based on type of care. For hospital or facility services, the claims are then sent to the next step in the Data iSight process that is used cost to determine payment.

180. Professional claims, like those billed by the Plaintiffs in this action, are distinct from hospital or facility claims. Professional claims are for the treatment provided directly by physicians, like Plaintiffs in this case. Professional claims were priced by a specific Data iSight process known internally at Multiplan as “DiP”, internal shorthand for “Data iSight Professional.”

181. DiP is a computer program that takes the codes transmitted by United and applies a convoluted algorithm to “edit” and recalculate claims payment rates.

**(c) Claims Editing**

182. Data iSight’s first step in processing claims is to apply “edits.” “Editing” claims modifies the billing codes on Providers’ billing forms to reduce the payment rates that the engine generates.

183. United and Multiplan each oversee different aspects of the claims editing, further demonstrating their joint management and control of the enterprise.

184. Three technical variables fuel the rates the Data iSight engine produces: Conversion Factors, Relative Value Units, and Geographic Practice Cost Indices. Data iSight borrowed these terms and their application from the Medicare Program.

**(d) Medicare Inputs**

185. The DiP software applies cost adjustments from Medicare in calculating physician payments. DiP adjusts the payment amounts based on “Conversion Factors” (hereinafter “CFs”), “Relative Value Units” (hereinafter “RVUs”) and “Geographic Practice Cost Index” (hereinafter GPCI) inputs.

**(e) Conversion Factors**

186. The application of Medicare billing mechanics is incompatible with calculation of “reasonable” or “usual, customary, and reasonable” (“UCR”) payment rates. Medicare reimbursement rates are not established based on the charges of similar providers in the same geographic area and are not subject to state regulation.

187. To generate a “reasonable” or UCR payment rate, the Data iSight product applies a “conversion factor” or “CF” to the Medicare payment rate.

188. This hidden transformation lie at heart of the underpayment scheme.

189. Medicare does not have a unique payment rate for the professional services of emergency room physicians.

190. Data iSight has created its own CF for the professional services of emergency room physicians.

191. The CF Data iSight applies is derived from a database created by Intercontinental Medical Statistics (“IMS”), a company that purchases data from pharmacies, insurers, and electronic medical record software, anonymizes it, and sells the data back, primarily to drug companies.

192. While Multiplan represents that the IMS database contains billions of claims, it actually only contains tens of millions of claims. In terms of scale, the FAIR Health dataset contains approximately 100 data points for every one contained within the IMS dataset.

193. IMS is now known as IQVIA. The database is not public, is not vetted, is not comprehensive, and is designed to sell itself. Multiplan paid hundreds of thousands of dollars a year to access the information IMS compiled. Multiplan chose this database despite already having access to the FAIR Health Database discussed *infra*.

194. By using the IQVIA data set, the payment rate that is ultimately calculated through Data iSight is even further removed from the usual and customary rate than was the Ingenix rate. The deeply flawed Ingenix data set contained commercial charge data, albeit heavily manipulated.

195. Despite IQVIA costing substantially more to utilize than FAIR Health data, which is available to United and Multiplan for a nominal fee, the added expense for IQVIA is well worth it to United and Multiplan because of its opaque nature and ready susceptibility of its data to manipulation. Further, IQVIA is not accessible to the general public, preventing any independent verification or accountability of its contents and use.

196. Multiplan chose this database because it knew that the IMS/IQVIA data could be readily manipulated using the Data iSight product, producing the artificially lower payments rates that Multiplan and United desired.

197. The IMS/IQVIA database more readily lends itself to the “reverse engineering” accomplished by Data iSight, whereby the payment rate was predetermined.

198. The IMS database that Data iSight used to power its calculations was secret, proprietary, and unvetted. In other words, the IMS database fulfilled the same purpose as the Ingenix database. Both were manipulated to produce fraudulently low underpayment rates.

199. The rates DiP creates are untethered to services actually provided. Instead, they are based on a formula whose base value stems from a methodology with no clear relationship to the amounts charged by other providers for the services provided.

200. DiP used the IMS database on an undifferentiated nationwide basis, meaning that geography is not taken into consideration when calculating the CF. Instead of using the prevailing UCR rates in a local area, DiP applied Medicare’s location-based GPCI cost adjustment factor discussed below.

**(f) RVUs and GPICs**

201. RVUs<sup>12</sup> and GPICs<sup>13</sup> are components that are used to calculate the amount that Medicare will pay for a claim. They are not based on usual and customary rates; instead, the

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<sup>12</sup> An RVU is a Relative Value Unit. It is a measure of value used in Medicare’s reimbursement formula. Medicare’s reimbursement formula is based on the resources that it takes to provide a service, not the usual and customary charges. RVUs are based on Medicare’s determination of the value of the resources used to provide a service divided into three separate RVU values: one for physician work, one for practice expense, and one for malpractice insurance expense.

<sup>13</sup> A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure’s relative value unit (i.e., the RVUs for



210. Typically, Multiplan was paid a fee equal to a percentage of the “margin” or “savings” amount, i.e. the difference between the target amount sent over by United with the claim, and the amount of the new, low payment that Multiplan’s Data iSight calculated.

211. The dollar amount that United ultimately paid for the claims in this case was the lowest of three numbers: Target Price, Billed Amount, or DiP. In every case, the compensation structure agreed upon between Multiplan and United incentivized artificially low payments.

212. United would represent, among other things, that Data iSight derived payment was comparable to, and based on, what similar providers in Plaintiffs’ geographic area charged for the same or similar services. In fact, the purpose of the scheme was to produce a rate that was far lower than any reasonable or customary rate, and indeed, was not based on charges at all.

## **6. Marketing the Conspiracy**

213. Multiplan markets Data iSight to United and other insurers as a product capable of underpaying claims discreetly and with minimal complaints from health care providers. Multiplan explained to United that its Data iSight tool could be deployed in the ER provider context to drastically reduce United’s payments to non-participating ER providers.

214. Multiplan and United developed and implemented a scheme to underpay ER physicians without facing pushback from their insureds, precisely because patient responsibility is limited by statute.

215. United believes that use of the “independent” Data iSight product will shield it from liability.

216. United also misrepresents to insureds and insurance plans how much it pays out in claims by claiming certain amounts of “savings.”











**(d) The Network Access Agreement**

244. The National Network Access Agreement (“Agreement”) is a written contract between United and Multiplan that sets out how United and Multiplan profit from the proceeds of the DiP-generated underpayments.

245. Exhibits and Amendments to this Agreement detail the fee and incentive structure between the parties and how United compensates Multiplan for access to the DiP methodology. It also discusses how Multiplan receives a percentage of the margin between the target rate and the artificially low number Data iSight delivers as a rate of payment.

246. Although on its face it may appear to be a benign legal contract between businesses, the Agreement actually is intended to provide cover and a vehicle for the parties to share the ill-gotten gains of the DiP pricing methodology.

**7. Misrepresentations in Furtherance of the Conspiracy**

247. In furtherance of the conspiracy between United and Multiplan to artificially reduce payments using Data iSight, both entities have engaged in numerous false and misleading statements through the mails and wires, described more fully above and in the following discussion.

**(a) Provider Remittance Advice forms and Explanations of Benefits**

248. Every time a claim is processed by United, United’s claim handling system sends to the healthcare provider an alleged explanation of how and why the claim was processed in a specific way. That document, called a “Provider Remittance Advice” (hereinafter “PRA”), is generally transmitted to the treated patient and the treating provider via the United States Postal Service.

MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF- NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM, THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT, WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

251. As detailed below, for emergency treatment that Plaintiffs provided United Subscribers during the period May 15, 2020, to June 30, 2020, United sent over the mails and wires numerous PRAs and EOBs containing this or a substantially similar notation.

253. The PRAs and EOBs that United sent in this action are false and were created with the intent to deceive the documents' recipients -- including Plaintiffs, patients, and the plans that United administers -- into believing that the Data iSight process is transparent, defensible, and

market-tested, and results in a fair price using amounts generally accepted by providers as full payment for services. In fact, as set forth above and in Part F below, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable payment rate. Its rates are not defensible or reasonable.

254. The Defendants know that the rates that Data iSight has allowed are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

255. They know this because when a provider challenges the payment, Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the provider persists long enough in the process.

256. This process to contest the unreasonable payment takes weeks to conclude for the provider and is impracticable to follow for every claim – a fact that United is aware of.

257. Thus, absent providers taking the time to chase every claim, Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

258. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until Plaintiffs challenge its determinations continually harms Plaintiffs, in that, even if Plaintiffs eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens Plaintiffs with excessive administrative time and expense and deprives Plaintiffs of their right to prompt payment of clean claims under New Jersey's HCAPPA statute and related regulation.

**(b) Website misrepresentations**

259. Multiplan’s and United’s websites contain additional misrepresentations relating to the process by which Data iSight calculates health care reimbursements.

260. In its healthcare provider portal, Data iSight describes its methodology for payment determinations as being “calculated using paid claims data from millions of claims...The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor.”

261. Multiplan’s website further describes Data iSight’s process as using “cost- and reimbursement-based methodologies” and represents that it has been “[v]alidated by statisticians as effective and fair.”

262. These statements on Multiplan’s website are demonstrably false. Again, as set forth above and in Part F, below, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable payment rate. Its rates are not defensible or reasonable.

263. Moreover, Defendants furthered the scheme by using false representations to providers promising geographic adjustments to allowed rates. Indeed, on its online provider portal, Data iSight falsely claims that “[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area.”

264. Multiplan further falsely states on its website that:

For professional claims where actual costs aren’t readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] [the Centers for Medicare and Medicaid Services (“CMS”)] Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly- available database of paid claims.

267. Contrary to this misrepresentation, none of the claims at issue in this litigation were paid at the 80th percentile of the FAIR Health benchmark despite both United and Multiplan having access to it. The 80th percentile of FAIR Health Benchmark databases clearly shows that payment for the above non-participating provider charges, when based on a geographically adjusted basis, would not only vary widely, but also be much higher than the amounts that United “allowed” on Plaintiffs’ claims, as described in Part F, below.

269. Defendant Data iSight’s website further claims to offer “Transparency for You, the Provider,” and that the “website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated.”

<sup>14</sup> <https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits> (last visited October 27, 2020).



271. This concealment was designed to, and does, prevent providers such as Plaintiffs from discovering that the payment they receive is anything but “appropriate.” However, Plaintiffs were able to discover that United’s payments were anything but “appropriate.”

**F. Since Plaintiffs Have Left United’s Network, United Has Used Data iSight to Underpay Plaintiffs**

**1. Plaintiffs Have Continued to Treat and Timely Bill United for the Services Their Physicians Provide to United Subscribers**

272. As noted above, since Plaintiffs have left United’s network, Plaintiffs have continued to provided emergency treatment to United Subscribers, as they are required to do by law.

273. In just the first 45 days after Plaintiffs were forced out of United’s network, Plaintiffs’ physicians provided emergency department treatment to 1,520 United Subscribers.

274. For the healthcare claims at issue here, the hospital where the emergency services were provided was responsible for obtaining and did obtain the patient’s insurance information and demographics.

275. The emergency healthcare billing process operated as follows: patients were admitted to Emergency Departments (“EDs”) of hospitals where they were screened and stabilized without inquiry into their ability to pay.

276. The screening and stabilizing providers recorded the services they provided in medical record “charts.”

277. If patients were insured, they provided their insurance information and patient demographics to the hospital’s billing department.

278. The hospital’s billing department then sent the patient’s demographics, medical records, and insurance information to the Plaintiffs.

279. This is the standard practice for hospitals that contract with outside groups to provide emergency services.

280. The Plaintiffs' billing departments transcribed patients' medical charts into standardized billing codes, created invoices with standard charges, medical coding, patient demographics, and submitted the invoices electronically to United.

281. Regardless of the specific United subsidiary or entity responsible for administering the patient's plan, all invoices were submitted through a common United portal.

282. Every claim at issue was approved for payment by United.

283. The invoices were all submitted using standardized claims forms called HCFA-1500 forms. Every claim at issue in this case was submitted directly to United or its subsidiaries.

284. In billing United for the emergency department services that Plaintiffs' physicians provide to United Subscribers, Plaintiffs follow the industry-standard Current Procedural Technology ("CPT") coding system established by the American Medical Association ("AMA") and routinely accepted by United and other private and governmental payors.

285. The most commonly used CPT codes billed by Plaintiffs' emergency department physicians are CPT Codes 99284, 99285, and 99291.

286. According to United's "Emergency Department (ED) Facility Evaluation and Management (E&M) Coding Policy," (hereinafter "United Emergency Department Policy"),<sup>15</sup> CPT Code 99284 applies to the following:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies

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<sup>15</sup> See <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Emergency-Department-Facility-Evaluation-Mgmt-Policy.pdf> (last visited October 27, 2020).

applies to the following:

288. According to the same United Emergency Department Policy, CPT Code 99291

289. For emergency department treatment of lesser severity provided by Plaintiffs' physicians, Plaintiffs bill United using CPT Codes 99281, 99282, and 99283.

291. After receiving the claims, they were processed, approved for payment, the amount was determined, and the claims were paid to the hospital and providers with accompanying notes about how much the patient owed and United's explanation for the amount it

**2. United Has Processed Plaintiffs' Claims Through Data iSight and Dramatically Underpaid Plaintiffs' Claims**

292. However, instead of paying a “reasonable” rate to Plaintiffs, since Plaintiffs have left United’s network, Defendants have used Data iSight to generate a fraudulent “reasonable” rate as justification for underpaying most of Plaintiffs claims.

293. For the healthcare claims at issue, the Plaintiffs were reimbursed at a rate that was far below the rates that United had paid Plaintiffs under their agreements with UHIC and UHC-NJ for many years, and far below what would be considered reasonable by any standard.

294. Specifically, of the 1,520 United Subscribers that Plaintiffs’ emergency physicians treated in just the first 45 days after Plaintiffs left United’s network, upon information and belief, United processed at least 1,215 of these claims through Data iSight.

295. In doing so, United drastically underpaid Plaintiffs by more than \$1.1 million on these 1,215 claims, even after taking into account Patient Responsibility, broken down as follows:

a. Atlantic ER Physicians Team Pediatric Associates, PA: total United underpayments of \$2,843 on 3 patient visits;

b. Emergency Care Services of NJ, PA: total United underpayments of \$52,913 on 54 patient visits;

c. Emergency Physician Associates of North Jersey, PC: total United underpayments of \$460,260 on 456 patient visits;

d. Emergency Physician Associates of South Jersey, PC: total United underpayments of \$269,025 on 263 patient visits;

e. Emergency Physician Services of New Jersey, PA: total United underpayments of \$187,497 on 296 patient visits;

f. Middlesex Emergency Physicians, PA: total United underpayments of \$138,348 on 129 patient visits;

g. Plainfield Emergency Physicians, PA: total United underpayments of \$10,414 on 14 patient visits.

298. Of the 1,215 of Plaintiffs' claims that United processed through Data iSight for services provided between May 15 - June 30, 2020, 1,018 were for non-COVID-19 patients. As the following table indicates, regardless of the CPT code or combination of codes Plaintiffs billed United, United's average reimbursement was just a fraction of Plaintiffs' billed charges where the claim was processed through Data iSight:

**NON-COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS'  
EMERGENCY DEPARTMENT PHYSICIANS:**

**MAY 15 - JUNE 30, 2020 (claims processed through Data iSight)**

| CPT CODE                         | Total # of Claims | Average Billed Charge Per Claim | Average Allowed by United Per Claim (Average % of Billed Charges) | Average Underpayment per Claim | Total Underpayment  |
|----------------------------------|-------------------|---------------------------------|-------------------------------------------------------------------|--------------------------------|---------------------|
| 93010                            | 5                 | \$96.80                         | \$24.36 (25.17%)                                                  | \$72.44                        | \$362.18            |
| 99281                            | 2                 | \$221.00                        | \$106.68 (48.27%)                                                 | \$112.33                       | \$224.65            |
| 99281 combined with another code | 1                 | 216.00                          | \$57.13 (26.45%)                                                  | \$158.87                       | \$158.87            |
| 99282                            | 16                | \$453.75                        | \$125.81 (27.73%)                                                 | \$327.94                       | \$5,347.04          |
| 99282 combined with another code | 12                | \$448.58                        | \$133.77 (29.82%)                                                 | \$314.81                       | \$3,777.71          |
| 99283                            | 103               | \$709.21                        | \$188.55 (26.59%)                                                 | \$520.34                       | \$53,594.53         |
| 99283 combined with another code | 103               | \$931.81                        | \$259.37 (27.84%)                                                 | \$672.44                       | \$69,260.97         |
| 99284                            | 179               | \$1,086.88                      | \$324.24 (29.83%)                                                 | \$761.64                       | \$136,333.25        |
| 99284 combined with another code | 125               | \$1,370.14                      | \$398.62 (29.09%)                                                 | \$971.28                       | \$121,410.14        |
| 99285                            | 269               | \$1,576.00                      | \$478.85 (30.38%)                                                 | \$1,097.65                     | \$295,267.38        |
| 99285 combined with another code | 167               | \$1,682.37                      | \$469.47 (27.90%)                                                 | \$1,212.62                     | \$202,506.80        |
| 99291                            | 21                | \$1,785.00                      | \$732.08 (41.01%)                                                 | \$1,052.92                     | \$22,111.35         |
| 99291 combined with another code | 15                | \$2,050.93                      | \$657.59 (32.06%)                                                 | \$1,350.58                     | \$20,258.72         |
| <b>TOTAL</b>                     | <b>1018</b>       | <b>\$1,298.54</b>               | <b>\$383.56 (29.54%)</b>                                          | <b>\$914.06</b>                | <b>\$930,513.59</b> |

299. United’s pattern of underpaying Plaintiffs’ out-of-network claims through Data iSight applied equally to COVID-19 patients, despite the global pandemic and United’s special coverage obligations under the FFCRA and the CARES Act. Specifically, United processed 197 of Plaintiffs’ claims for services provided between May 15 - June 30, 2020, for COVID-19 patients. As the following table indicates, again, for each of the specific CPT codes Plaintiffs billed to United for COVID-19 patients, United’s average reimbursement remained just a fraction of Plaintiffs’ billed charges where the claim was processed through Data iSight:

**COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS’ EMERGENCY  
DEPARTMENT PHYSICIANS:**

**MAY 15 - JUNE 30, 2020 (claims processed through Data iSight)**

| CPT<br>CODE | Total #<br>of<br>Claims | Average Billed<br>Charge Per<br>Claim | Average Allowed by<br>United Per Claim<br>(Average % of Billed<br>Charges) | Average<br>Underpayment<br>per Claim | Total<br>Underpayment |
|-------------|-------------------------|---------------------------------------|----------------------------------------------------------------------------|--------------------------------------|-----------------------|
| 99283       | 17                      | \$574.43                              | \$183.10 (31.88%)                                                          | \$381.76                             | \$6,489.89            |
| 99284       | 9                       | \$985.78                              | \$277.53 (28.15%)                                                          | \$708.25                             | \$6,374.27            |
| 99285       | 151                     | \$1,497.64                            | \$469.68 (31.36%)                                                          | \$1,024.77                           | \$154,740.15          |
| 99291       | 20                      | \$1,853.15                            | \$693.02 (37.40%)                                                          | \$1,159.12                           | \$23,182.34           |
| TOTAL       | 197                     | \$1,430.69                            | \$458.95 (32.08%)                                                          | \$968.46                             | \$190,786.65          |

300. The Defendants know that the rates that Data iSight have allowed for Plaintiffs’ claims since May 15, 2020, as depicted above, are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate. Notably, these average allowed rates are substantially lower than the rates that United has allowed for the 305 of Plaintiffs’ claims not processed through Data iSight between May 15 - June 30, 2020.

301. Specifically, as the following table indicates, for non-COVID-19 claims for services between May 15 - June 30, 2020, where, upon information and belief, United did not process the claims through Data iSight, United’s average allowed payments were close to Plaintiffs’ billed charges:

**NON-COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS'  
EMERGENCY DEPARTMENT PHYSICIANS:**

**MAY 15 - JUNE 30, 2020 (claims not processed through Data iSight)**

| CPT CODE                         | Total # of Claims | Average Billed Charge Per Claim | Average Allowed by United Per Claim (Average % of Billed Charges) | Average Underpayment per Claim | Total Underpayment |
|----------------------------------|-------------------|---------------------------------|-------------------------------------------------------------------|--------------------------------|--------------------|
| 93010                            | 1                 | \$102.00                        | \$91.80 (90.00%)                                                  | \$10.20                        | \$10.20            |
| 99281                            | 4                 | \$109.75                        | \$100.25 (91.34%)                                                 | \$9.50                         | \$38.00            |
| 99281 combined with another code | 2                 | \$111.50                        | \$106.20 (95.25%)                                                 | \$5.30                         | \$10.60            |
| 99282                            | 13                | \$491.08                        | \$468.00 (95.30%)                                                 | \$23.08                        | \$300.00           |
| 99282 combined with another code | 2                 | \$237.00                        | \$213.30 (90.00%)                                                 | \$23.70                        | \$47.40            |
| 99283                            | 34                | \$705.62                        | \$664.94 (94.19%)                                                 | \$40.68                        | \$1,383.00         |
| 99283 combined with another code | 24                | \$993.59                        | \$905.89 (91.17%)                                                 | \$93.26                        | \$2,518.10         |
| 99284                            | 43                | \$1,041.63                      | \$975.73 (93.67%)                                                 | \$65.90                        | \$2,833.50         |
| 99284 combined with another code | 21                | \$1,293.71                      | \$1,181.71 (91.34%)                                               | \$112.00                       | \$2,352.10         |
| 99285                            | 72                | \$1,606.96                      | \$1,505.31 (93.67%)                                               | \$101.65                       | \$7,318.68         |
| 99285 combined with another code | 43                | \$1,682.14                      | \$1,532.37 (91.10%)                                               | \$149.77                       | \$6,439.98         |
| 99291                            | 1                 | \$1,860.00                      | \$1,674.00 (90.00%)                                               | \$186.00                       | \$186.00           |
| 99291 combined with another code | 1                 | \$5,572.00                      | \$4,340.00 (77.89%)                                               | \$1,232.00                     | \$1,232.00         |
| <b>TOTAL</b>                     | <b>264</b>        | <b>\$1,234.33</b>               | <b>\$1,140.88 (92.43%)</b>                                        | <b>\$93.45</b>                 | <b>\$24,669.56</b> |



May 15 - June 30, 2020, where United did not process the claims through Data iSight, United's average allowed payments were again close to Plaintiffs' billed charges

**COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS' EMERGENCY DEPARTMENT PHYSICIANS:**

**MAY 15 - JUNE 30, 2020 (claims not processed through Data iSight)**

| CPT CODE | Total # of Claims | Average Billed Charge Per Claim | Average Allowed by United Per Claim (Average % of Billed Charges) | Average Underpayment per Claim | Total Underpayment |
|----------|-------------------|---------------------------------|-------------------------------------------------------------------|--------------------------------|--------------------|
| 99283    | 3                 | \$472.00                        | \$447.40 (94.79%)                                                 | \$24.60                        | \$73.80            |
| 99284    | 5                 | \$1,144.60                      | \$1,012.96 (88.50%)                                               | \$131.64                       | \$658.20           |
| 99285    | 32                | \$1,519.78                      | \$1,393.09 (91.66%)                                               | \$126.69                       | \$4,054.20         |
| 99291    | 1                 | \$1,906.00                      | \$1,618.20 (84.90%)                                               | \$287.80                       | \$287.80           |
| TOTAL    | 41                | \$1,406.78                      | \$1,283.02 (91.20%)                                               | \$123.76                       | \$5,074.00         |

303. As further evidence that the Data iSight rates are wholly inconsistent with what would be considered “reasonable” reimbursement rates by any standard, with the exception of Code 99281, the average Data iSight rates are substantially lower than the rates to which United agreed under its own recent terminated Participation Agreements with Plaintiffs. In fact, most of the rates Data iSight came up with were lower than the rates in place under those contracts in 2008, as the following table indicates:

**Average Data iSight Rates for Plaintiffs Claims (May 15 - June 30, 2020)  
versus United Contracted Rates**

| CPT CODE | Data iSight Allowed Rate for non-COVID-19 claims (May 15-June 30, 2020) | Data iSight Allowed Rate for COVID-19 claims (May 15-June 30, 2020) | Contracted Rates (May 15, 2016-May 14, 2020) | Contracted Rates with Plaintiffs (June 18, 2008 - June 17, 2009) |
|----------|-------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------|
| 99281    | \$106.68                                                                | --                                                                  | \$85.22                                      | \$73.27                                                          |
| 99282    | \$125.81                                                                | --                                                                  | \$145.96                                     | \$121.74                                                         |
| 99283    | \$188.55                                                                | \$183.10                                                            | \$327.77                                     | \$273.36                                                         |
| 99284    | \$324.46                                                                | \$277.53                                                            | \$511.24                                     | \$426.41                                                         |
| 99285    | \$478.85                                                                | \$469.68                                                            | \$800.13                                     | \$667.36                                                         |
| 99291    | \$732.08                                                                | \$693.02                                                            | \$1,199.27                                   | \$1,000.27                                                       |

306. Plaintiffs have been harmed in their businesses and property by Defendants' conduct. They were deprived of the fair value of their services and lied to by the Defendants who told them that their reimbursements were consistent with an objective calculation of reasonable rates and comparable with rates charged by their local competitors.

308. Worst of all, there is no end in sight. The use of Data iSight has become the Defendants' and the Enterprise's regular way of doing business. As noted above, United Subscribers continue to receive treatment in the emergency departments of hospitals staffed by Plaintiffs' physicians, and Plaintiffs are legally required to treat these patients. Unless and until the Courts or law enforcement officials compel an end to United's and Multiplan's claims administration schemes, United will continue to illegally and aggressively underpay Plaintiffs --

and numerous other out-of-network emergency physicians around the country -- every day, aided by the fraudulent Data iSight methodology administered by Multiplan.

309. Unless stopped, Defendants' conduct will ultimately force Plaintiffs and other out-of-network emergency department physicians to accept unreasonably low in-network contracts that do not cover their operating costs, or more likely drive them out of business.

## **CAUSES OF ACTION**

### **COUNT ONE**

#### ***Quantum Meruit--***

#### **Against UnitedHealth Group, Inc. UnitedHealthcare Insurance Company, and UnitedHealthCare of New Jersey, Inc.**

310. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

311. Under New Jersey law, a cause of action for *Quantum Meruit* requires (1) the performance of services in good faith, (2) the acceptance of the services by the person to whom they are rendered, (3) an expectation of compensation therefor, and (4) the reasonable value of the services.

312. Since leaving United's network on May 15, 2020, to comply with their ethical and legal obligations under federal and New Jersey law, Plaintiffs have continued to provide emergency medical treatment and services to United Subscribers in good faith.

313. United could not lawfully prevent their members from seeking emergency medical care from the Physicians. Thus, the parties were, in effect, compelled to do business with each other.

314. Given the nature of these relationships, an equitable obligation arises to account for the value of the services Plaintiffs provided to United Subscribers.



## COUNT TWO

### **Violation of New Jersey Health Claims Authorization, Processing and Payment Act ("HCAPPA")**

#### **Against UnitedHealth Group, Inc. UnitedHealthcare Insurance Company, and UnitedHealthCare of New Jersey, Inc.**

323. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

324. HCAPPA requires health insurers such as United to pay health care providers' claims promptly, provided that the claims meet the criteria for payment set forth in *N.J.S.A. 17B:26-9.1(d)(1)*, *N.J.S.A. 17B:27-44.2(d)(1)* and *N.J.S.A. 26:2J-8.1(d)(1)*.

325. Specifically, for out-of-network emergency claims governed by the OON Act post August 30, 2018 -- such as the claims for the emergency treatment Plaintiffs' physicians have provided to United Subscribers since May 15, 2020 -- New Jersey law requires that such claims be paid in full no more than 50 days after electronic submission, except to the extent disputed in accordance with the procedures of the OON Act. *See N.J.S.A. 26:2SS-9.*

326. Plaintiffs' claims for the emergency treatment they provided to United Subscribers since May 15, 2020, meet all the criteria for payment under HCAPPA, *N.J.S.A. 17B:26-9.1(d)(1)*, *N.J.S.A. 17B:27-44.2(d)(1)* and *N.J.S.A. 26:2J-8.1(d)(1)*. As described more fully above, on the dates the services were provided, the United covered the out-of-network emergency services Plaintiffs' physicians provided to United Subscribers, and Plaintiffs' agents submitted the claims to United on the appropriate claim forms.

327. However, as described more fully above, United failed to remit full reimbursement of Plaintiffs' charges for healthcare services, or provide a written explanation for the failure to pay



333. Plaintiffs have had an existing and reasonable expectation of an economic benefit from United in the form of reasonable reimbursement from United for the medically necessary emergency service Plaintiffs provided to United Subscribers.

334. As detailed more fully above, Multiplan had full knowledge of Plaintiffs' reasonable expectations.

335. Multiplan's actions set forth above in deploying the Data iSight methodology to paper over United's underpayments to Plaintiffs have interfered with Plaintiffs' reasonable expectations.

336. Multiplan's actions have been malicious in that Multiplan had no legal justification to interfere with Plaintiffs' expectation of a reasonable reimbursement from United. Importantly, Multiplan has sought to paper over United's underpayments through false and misleading statements and other conduct, described more fully above.

337. But for Multiplan's interference, Plaintiffs had a reasonable probability of continuing to receive reasonable reimbursement for the medically necessary emergency service Plaintiffs provided to United Subscribers.

338. As a direct and proximate result of Multiplan's conduct, Plaintiffs have suffered and will continue to suffer irreparable harm and monetary damages.

#### **COUNT FOUR**

#### **NJ RICO-- Violation of *N.J.S.A. 2C:41-2(c)* Against All Defendants**

339. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

340. Each of the Plaintiffs is a "person" within the meaning of *N.J.S.A. 2C:41-1(b)*.

341. Each of the Defendants is a "person" within the meaning of *N.J.S.A. 2C:41-1(b)*.

342. The United-Multiplan Enterprise is an “enterprise” within the meaning of *N.J.S.A.* 2C:41-1(c).

343. The United-Multiplan Enterprise is engaged in activities which affect trade or commerce for purposes of *N.J.S.A.* 2C:41-2(c).

344. Each of the Defendants is associated with the United-Multiplan Enterprise. Moreover, each of the Defendants has conducted or participated, directly or indirectly, in the conduct of the affairs of the United-Multiplan Enterprise through a pattern of racketeering activity within the meaning of *N.J.S.A.* 2C:41-1(a) and (d).

345. The pattern of racketeering activity under *N.J.S.A.* 2C:41-1(a) and (d), described more fully above, includes multiple and repeated acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3. Under this statute, a person is guilty of theft if he or she unlawfully takes, or exercises unlawful control over, moveable property with purpose to deprive him or her thereof, or unlawfully transfers any interest in immovable property of another with purpose to benefit himself or herself or another not entitled thereto. *N.J.S.A.* 2C:20-3(a), (b).

346. In violation of *N.J.S.A.* 2C:20-3(a), Defendants unlawfully took and exercised unlawful control of money rightfully belonging to Plaintiffs -- specifically, reimbursements to which Plaintiffs were entitled for the out-of-network emergency services that Plaintiffs’ physicians provided to United Subscribers. This money constitutes moveable property within the meaning of *N.J.S.A.* 2C:20-3(a). Defendants knew that they had no right to take or exercise control of these funds, yet took and/or controlled them anyway, with the purpose of depriving Plaintiffs of them.

347. Moreover, in violation of *N.J.S.A.* 2C:20-3(b), Defendants unlawfully transferred Plaintiffs’ rights and interests in being paid reasonable amounts for the out-of-network emergency services they provided to United Subscribers. These rights and interests constitute immovable



property within the meaning of *N.J.S.A. 2C:20-3(b)*. Defendants knew that they had no right to transfer Plaintiffs rights and interests in being paid reasonable amounts for their services away from Plaintiffs, yet they did so anyway, with the purpose of benefitting themselves and others not entitled to benefit from Plaintiffs' out-of-network emergency services.

348. The pattern of racketeering activity under *N.J.S.A. 2C:41-1(a)* and (d), described more fully above, also includes multiple and repeated acts of theft by deception in violation of *N.J.S.A. 2C:20-4*. Under this statute, a person is guilty of theft by deception if he or she purposely obtains the property of another by deception, which is defined to include situations in which a person, *inter alia*, "[c]reates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind," "[p]revents another from acquiring information which would affect his judgment of a transaction," or "[f]ails to correct a false impression which the deceiver previously created or reinforced...." *N.J.S.A. 2C:20-4(a)-(c)*.

349. In violation of *N.J.S.A. 2C:20-4(a)-(c)*, Defendants repeatedly obtained money that rightfully belonged to Plaintiffs through repeated acts of deception within the meaning of this statute, described more fully above. These acts of deception included, but were not limited to, misrepresentations as to the validity of the Data iSight methodology and the validity of United's reimbursements to Plaintiffs pursuant to that methodology.

350. The pattern of racketeering activity also includes multiple and repeated acts of theft of services in violation of *N.J.S.A. 2C:20-8*. Under this statute, a person commits theft of services if, *inter alia*, he or she purposely obtains professional services by deception or threat, or by other means, to avoid payment for the service. *N.J.S.A. 2C:20-8(a)*.

351. In violation of *N.J.S.A. 2C:20-8(a)*, Defendants repeatedly obtained for United Subscribers hospital emergency treatment provided by Plaintiffs that Defendants knew were

available only for compensation at reasonable rates. Defendants did so using deception and other means designed to avoid full payment for the services, described more fully above, including Defendants' deployment of the Data iSight methodology, their misrepresentations as to the validity of the Data iSight methodology and the validity of United's reimbursements to Plaintiffs pursuant to that methodology, and other deceptive conduct, described more fully above.

352. The pattern of racketeering also includes multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of "racketeering activity" under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO's definition of "racketeering activity" under N.J.S.A. 2C:41-1(a)(2). Specifically, Defendants repeatedly and continuously used the mails and wires in furtherance of a scheme to defraud Plaintiffs, United Subscribers, and members of the public into believing that the Data iSight methodology is "transparent," "defensible," and "market tested," and results in a "fair price using amount generally accepted by providers a full payment for services." Defendants made numerous statements over the mails and wires in furtherance of this scheme and with the specific intent to deceive. The express purpose of Defendants' scheme to defraud is to deprive Plaintiffs and other hospital emergency physicians of fair and reasonable reimbursements for the services they render to United Subscribers.

353. Each Defendant has engaged in at least two incidents of racketeering activity that have the same or similar purposes, results, participants, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

354. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar purposes, in that they sought to, and did, unlawfully avoid reimbursing Plaintiffs as required by law.

355. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has similar results, in that they sought to, and did, unlawfully avoid reimbursing Plaintiffs as required by law.

356. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar participants, including but not limited to Defendants.

357. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar victims, consisting of the Plaintiffs and other out-of-network providers, whom Defendants have schemed to under reimburse based upon false and fraudulent data.

358. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that is not isolated, rather those incidents are part of the Defendants regular way of doing business and are regularly and systematically engaged in by them to deny out-of-network providers, including Plaintiffs, appropriate reimbursement.

359. The last incident of racketeering activity engaged in by Defendants occurred within ten years after a prior incident.

360. The incidents of racketeering activity involve under-reimbursement for services provided to different persons, on different dates, at different locations, by different physicians employed by different providers.

361. Defendants' conduct poses a continuing threat of racketeering activity, as described below.

362. Defendants have engaged in thousands of incidents of racketeering activity directed at Plaintiffs and other providers.



370. The United-Multiplan Enterprise is an “enterprise” within the meaning of *N.J.S.A.* 2C:41-1(c).

371. The United-Multiplan Enterprise is engaged in activities which affect trade or commerce for purposes of *N.J.S.A.* 2C:41-2(c).

372. Defendants conspired with each other, within the meaning of *N.J.S.A.* 2C:41-2(d), to violate the provisions of *N.J.S.A.* 2C:41-2(c).

373. Specifically, United and Multiplan each agreed and intended, or adopted the goal of furthering or facilitating, the following endeavor: to conduct or participate, directly or indirectly, in the management and operation of the affairs of the United-Multiplan enterprise, through a pattern of racketeering activity in violation of *N.J.S.A.* 2C:41-2(c).

374. As set forth above, Defendants have been and continue to be part of an association-in-fact enterprise within the meaning of N.J. Stat. Ann. § 2C:41-1(c).

375. Defendants have agreed to a conspiracy that has as its objective a substantive violation of the RICO Act.

376. Each Defendant has agreed to participate directly or indirectly in the conduct of the affairs of the Enterprise by agreeing to commit, or aid other members of the conspiracy to commit, at least two predicate acts.

377. The Defendants acted knowingly and purposely with knowledge of the unlawful objective of the conspiracy and with the intent to further its unlawful objective.

378. As a direct and proximate result of Defendants’ violations of N.J. Stat. Ann. § 2C:41-2(d), the Plaintiffs have been injured in their businesses and property, suffering financial losses.

more fully above, includes multiple and repeated acts of theft by unlawful taking in violation of *N.J.S.A. 2C:20-3(a) and (b)*, theft by deception in violation of *N.J.S.A. 2C:20-4*, theft of services in violation of *N.J.S.A. 2C:20-8*, and multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of “racketeering activity” under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO’s definition of “racketeering activity” under *N.J.S.A. 2C:41-1(a)(2)*.

380. For example, as set forth more fully above, United has conspired with Multiplan to engage in acts of theft by unlawful taking, theft by deception, theft of services, and schemes to defraud Plaintiffs, United Subscribers, and members of the public into believing that the Data iSight methodology is “transparent,” “defensible,” and “market tested,” and results in a “fair price using amount generally accepted by providers a full payment for services, rather than what it really is -- an effort to paper over patently unreasonable and unlawful health care reimbursement payments.

381. In addition, as described more fully above, Defendants have used the wires and mails in furtherance of their schemes to defraud, and they have conspired to engage in these schemes for the express purpose of depriving Plaintiffs of money and other property.

382. As a direct result of United's violations of *N.J.S.A. 2C:41-2(d)* by conspiring to violate *N.J.S.A. 2C:41-2(c)*, Plaintiffs have suffered substantial and direct injury to their businesses or property within the meaning of *N.J.S.A. 2C:41-4(c)*, including, but not limited to: (i) lost revenue from United's intentional underpayment of claims submitted for reimbursement for emergent medically necessary treatment of United Subscribers; (ii) lost revenue from Defendants' intentional diversion of healthcare reimbursements that are otherwise due and payable to Plaintiffs;

WHEREFORE, Plaintiffs pray for relief and judgment against all Defendants, jointly and severally, as follows:

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9. Order the restitution monies and property unlawfully obtained or retained by the Defendants;

10. Exemplary and/or punitive damages under the New Jersey Punitive Damages Act, *N.J.S.A. 2A:15-5.9 to -5.12* for Defendants' intentional, willful, wanton, outrageous or malicious misconduct, characterized by their evil or rancorous motive, ill will and intent to injure Plaintiffs; or Defendants' gross recklessness or gross negligence evincing a conscious disregard for Plaintiffs' rights.

11. Such other and further relief as the Court deems just and proper.

**JURY DEMAND**

Plaintiffs hereby demand a trial by jury for each and every one of the foregoing claims so triable.

**DEMAND FOR PUNITIVE DAMAGES**

Pursuant to *N.J.S.A. 2A:15-5.11*, Plaintiffs hereby demand punitive damages on all of their claims against Defendants for which punitive damages are available.



## DESIGNATION OF TRIAL COUNSEL

Plaintiffs designate Anthony P. La Rocco, Esq., as trial counsel in this matter.

Respectfully submitted,

**K&L GATES LLP**

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Newark, NJ 07102  
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Fax: (973) 848-4001  
anthony.larocco@klgates.com  
george.barbatsuly@klgates.com  
stacey.hyman@klgates.com  
*Attorneys for Plaintiffs*

By: /s/ Anthony P. La Rocco, Esq.  
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

**R. 1:38-7(c) CERTIFICATION**

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with Rule 1:38-7(b).

Respectfully submitted,

**K&L GATES LLP**

One Newark Center, 10th Floor  
Newark, NJ 07102  
Phone: (973) 848-4000  
Fax: (973) 848-4001  
anthony.larocco@klgates.com  
george.barbatsuly@klgates.com  
stacey.hyman@klgates.com  
*Attorneys for Plaintiffs*

By: /s/ Anthony P. La Rocco, Esq. \_\_\_\_\_  
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

**R. 4:5-1 CERTIFICATION**

I certify that the matter in controversy is not the subject matter of any other action pending in any court or of any pending arbitration or administrative proceeding. I further certify that no other non-party should be joined in this action pursuant to R. 4:28, and no other non-party is subject to joinder pursuant to R. 4:29-1(b).

Respectfully submitted,

**K&L GATES LLP**

One Newark Center, 10th Floor

Newark, NJ 07102

Phone: (973) 848-4000

Fax: (973) 848-4001

anthony.larocco@klgates.com

george.barbatsuly@klgates.com

stacey.hyman@klgates.com

*Attorneys for Plaintiffs*

By: /s/ Anthony P. La Rocco, Esq.  
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

## Civil Case Information Statement

### Case Details: GLOUCESTER | Civil Part Docket# L-001196-20

**Case Caption:** ATLANTIC ER PHYSICIA NS TEAM P VS  
UNITEDHEALTH G

**Case Initiation Date:** 11/02/2020

**Attorney Name:** ANTHONY P LA ROCCO

**Firm Name:** K&L GATES LLP

**Address:** ONE NEWARK CENTER 10TH FL

NEWARK NJ 071025285

**Phone:** 9738484000

**Name of Party:** PLAINTIFF : Atlantic ER Physicians Team  
Pe

**Name of Defendant's Primary Insurance Company**  
(if known): Unknown

**Case Type:** TORT-OTHER

**Document Type:** NJ eCourts Case Initiation Confirmation

**Jury Demand:** YES - 6 JURORS

**Is this a professional malpractice case?** NO

**Related cases pending:** NO

**If yes, list docket numbers:**

**Do you anticipate adding any parties (arising out of same  
transaction or occurrence)?** NO

**Are sexual abuse claims alleged by: Atlantic ER Physicians Team  
Pe?** NO

**Are sexual abuse claims alleged by: Emergency Care Services of  
NJ?** NO

**Are sexual abuse claims alleged by: Emergency Physician  
Associates?** NO

**Are sexual abuse claims alleged by: Emergency Physician  
Associates?** NO

**Are sexual abuse claims alleged by: Emergency Physician  
Services o?** NO

**Are sexual abuse claims alleged by: Middlesex Emergency  
Physicians?** NO

**Are sexual abuse claims alleged by: Plainfield Emergency  
Physician?** NO

### THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

**Do parties have a current, past, or recurrent relationship?** YES

**If yes, is that relationship:** Business

**Does the statute governing this case provide for payment of fees by the losing party?** NO

**Use this space to alert the court to any special case characteristics that may warrant individual  
management or accelerated disposition:**

**Do you or your client need any disability accommodations?** NO

If yes, please identify the requested accommodation:

Will an interpreter be needed? NO

If yes, for what language:

Please check off each applicable category: Putative Class Action? NO Title 59? NO Consumer Fraud? NO

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule* 1:38-7(b)

11/02/2020  
Dated

/s/ ANTHONY P LA ROCCO  
Signed

GLOUCESTER COUNTY COURTHOUSE  
GLOUCESTER COUNTY CIVIL DIVISION  
1 NORTH BROAD ST  
WOODBURY NJ 08096

TRACK ASSIGNMENT NOTICE

COURT TELEPHONE NO. (856) 878-5050  
COURT HOURS 8:30 AM - 4:30 PM

DATE: NOVEMBER 03, 2020  
RE: ATLANTIC ER PHYSICIA NS TEAM P VS UNITEDHEALTH G  
DOCKET: GLO L -001196 20

THE ABOVE CASE HAS BEEN ASSIGNED TO: TRACK 2.

DISCOVERY IS 300 DAYS AND RUNS FROM THE FIRST ANSWER OR 90 DAYS  
FROM SERVICE ON THE FIRST DEFENDANT, WHICHEVER COMES FIRST.

THE PRETRIAL JUDGE ASSIGNED IS: HON JOHN C. EASTLACK JR

IF YOU HAVE ANY QUESTIONS, CONTACT TEAM 103  
AT: (856) 878-5050 EXT 15245.

IF YOU BELIEVE THAT THE TRACK IS INAPPROPRIATE YOU MUST FILE A  
CERTIFICATION OF GOOD CAUSE WITHIN 30 DAYS OF THE FILING OF YOUR PLEADING.  
PLAINTIFF MUST SERVE COPIES OF THIS FORM ON ALL OTHER PARTIES IN ACCORDANCE  
WITH R.4:5A-2.

ATTENTION:

ATT: ANTHONY P. LA ROCCO  
K&L GATES LLP  
ONE NEWARK CENTER 10TH FL  
NEWARK NJ 07102-5285

ECOURTS



Plaintiff  
ATLANTIC ER PHYSICIANS TEAM PEDIATRIC ASSOCIATES, PA, ET AL

Defendant  
UNITEDHEALTH GROUP, INC., ET AL

Person to be served: MULTIPLAN, INC, C/O  
CORPORATION SERVICE COMPANY, REGISTERED AGENT  
Address:  
80 STATE STREET  
ALBANY NY 12207

Attorney:  
K&L GATES LLP  
ONE NEWARK CENTER 10TH FLOOR  
NEWARK NJ 07102

Papers Served:  
SUMMONS, COMPLAINT & CASE INFORMATION STATEMENT TRACK ASSIGNMENT NOTICE

SUPERIOR COURT OF NEW  
JERSEY  
LAW DIVISION:  
GLOUCESTER COUNTY

DOCKET NO. GLO-L-001196-20

AFFIDAVIT OF SERVICE  
(for use by Private Service)

Cost of Service pursuant to R4:4-30

\$ \_\_\_\_\_

Service Data:

Served Successfully ☒ Not Served \_\_\_\_\_ Date: 11/24/20 Time: 8:30AM Attempts: \_\_\_\_\_

\_\_\_\_\_ Delivered a copy to him/her personally

Name of Person Served and relationship/title

\_\_\_\_\_ Left a copy with a competent household  
member over 14 years of age residing therein at place of abode.

JANE DOE (refused name)

☒ Left a copy with a person authorized to accept  
service, e.g. managing agent, registered agent, etc.

PERSON IN CHARGE AT THE OFFICE  
OF THE REGISTERED AGENT OF  
THE CORPORATION.

Description of Person Accepting Service:

Age: 60 Height: 5'1 Weight: 110 Hair: GREY Sex: Female Race: WHITE

Non-Served:

- ( ) Defendant is unknown at the address furnished by the attorney
- ( ) All reasonable inquiries suggest defendant moved to an undetermined address
- ( ) No such street in municipality
- ( ) No response on: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

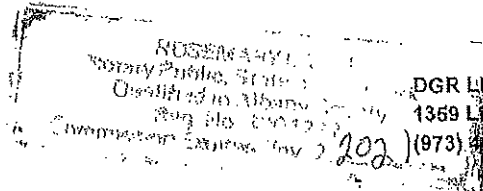
( ) Other: \_\_\_\_\_ Comments or Remarks \_\_\_\_\_

Subscribed and Sworn to me this  
24th day of NOV 2020

I, Robert Wexs, was at  
time of service a competent adult not having a direct  
interest in the litigation. I declare under penalty  
of perjury that the foregoing is true and correct.

Rosemary Corri  
Notary Signature

[Signature] 11/24/20  
Signature of Process Server Date



DGR LEGAL, INC.  
1369 Littleton Road, Morris Plains, NJ 07960-3000  
(973) 403-1700 Fax (973) 403-9222

Work Order No. 518577  
File No. GLO-L-001196-20



Plaintiff  
ATLANTIC ER PHYSICIANS TEAM PEDIATRIC ASSOCIATES, PA, ET AL

Defendant  
UNITEDHEALTH GROUP, INC., ET AL

Person to be served: UNITEDHEALTHCARE INSURANCE  
COMPANY

C/O CT CORPORATION SYSTEM.  
Address:  
185 ASYLUM STREET  
HARTFORD CT 06103

SERVED AT  
67 BURNSIDE AVENUE  
EAST HARTFORD CT 06108

Attorney:  
K&L GATES LLP  
ONE NEWARK CENTER 10TH FLOOR  
NEWARK NJ 07102

Papers Served:  
IMMONS, COMPLAINT & CASE INFORMATION STATEMENT TRACK ASSIGNMENT NOTICE

JERSEY  
LAW DIVISION:  
GLOUCESTER COUNTY

DOCKET NO. GLO-L-001196-20

**AFFIDAVIT OF SERVICE**  
(for use by Private Service)

Cost of Service pursuant to R4:4-30

\$ \_\_\_\_\_

**Service Data:**

Served Successfully X Not Served \_\_\_\_\_ Date: 11/19/2020 Time: 8:30 AM Attempts: \_\_\_\_\_

\_\_\_\_\_ Delivered a copy to him/her personally

\_\_\_\_\_ Name of Person Served and relationship/title

\_\_\_\_\_ Left a copy with a competent household  
member over 14 years of age residing therein at place of abode.

PERSON IN CHARGE AT THE OFFICE  
OF THE REGISTERED AGENT OF  
THE CORPORATION.

X Left a copy with a person authorized to accept  
service, e.g. managing agent, registered agent, etc.

Gary Scappini

**Description of Person Accepting Service:**

Age: 62 Height: 6'1" Weight: 205 Hair: Brown/gray Sex: Male Race: White

**Non-Served:**

- ( ) Defendant is unknown at the address furnished by the attorney  
( ) All reasonable inquiries suggest defendant moved to an undetermined address  
( ) No such street in municipality  
( ) No response on: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

( ) Other: \_\_\_\_\_ Comments or Remarks \_\_\_\_\_

Subscribed and Sworn to me this  
19 day of NOV, 2020

I, Christine Foran, was at  
time of service a competent adult not having a direct  
interest in the litigation. I declare under penalty  
of perjury that the foregoing is true and correct.

Notary Signature

AMY J. CHANTRY  
NOTARY PUBLIC  
MY COMMISSION EXPIRES 3/31/2023

Signature of Process Server

Date

11.19.2020

DGR LEGAL, INC.  
1359 Littleton Road, Morris Plains, NJ 07950-3000  
(973) 403-1700 Fax (973) 403-9222

Work Order No. 518053  
File No. 1304758.00003





Plaintiff  
ATLANTIC ER PHYSICIANS TEAM PEDIATRIC ASSOCIATES, PA, ET AL

Defendant  
UNITEDHEALTH GROUP, INC., ET AL

Person to be served: UNITEDHEALTH GROUP, INC.

C/O CT CORPORATION SYSTEM, REGISTERED AGENT

Address:  
9900 BREN ROAD EAST  
MINNETONKA MN 55343

SERVED AT:  
1010 DALE STREET NORTH  
ST. PAUL MN 55117

Attorney:

K&L GATES LLP  
ONE NEWARK CENTER 10TH FLOOR  
NEWARK NJ 07102

Papers Served:

SUMMONS, COMPLAINT & CASE INFORMATION STATEMENT TRACK ASSIGNMENT NOTICE

SUPERIOR COURT OF NEW  
JERSEY  
LAW DIVISION:  
GLOUCESTER COUNTY

DOCKET NO. GLO-L-001196-20

**AFFIDAVIT OF SERVICE**  
(for use by Private Service)

Cost of Service pursuant to R4:4-30

\$ \_\_\_\_\_

Service Data:

Served Successfully ☒ Not Served \_\_\_\_\_ Date: 11/23/2020 Time: 9:32 AM Attempts: \_\_\_\_\_

\_\_\_\_\_ Delivered a copy to him/her personally

Name of Person Served and relationship/title

\_\_\_\_\_ Left a copy with a competent household  
member over 14 years of age residing therein at place of abode.

Jana Floyd

☒ Left a copy with a person authorized to accept  
service, e.g. managing agent, registered agent, etc.

PERSON IN CHARGE AT THE OFFICE  
OF THE REGISTERED AGENT OF  
THE CORPORATION.

Description of Person Accepting Service:

Age: 30's Height: 5'7" Weight: 180 lbs. Hair: Red Sex: Female Race: Caucasian

Non-Served:

- ( ) Defendant is unknown at the address furnished by the attorney  
( ) All reasonable inquiries suggest defendant moved to an undetermined address  
( ) No such street in municipality  
( ) No response on: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

( ) Other: \_\_\_\_\_ Comments or Remarks \_\_\_\_\_

Subscribed and Sworn to me this

23 day of November 2020

I, Brandon Skopuli, was at  
time of service a competent adult not having a direct  
interest in the litigation. I declare under penalty  
of perjury that the foregoing is true and correct.

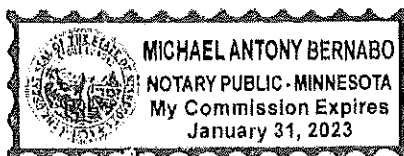
Michael Anthony Bernabo

Notary Signature

Signature of Process Server

11/23/2020

Date



DGR LEGAL, INC.  
1359 Littleton Road, Morris Plains, NJ 07950-3000  
(973) 403-1700 Fax (973) 403-9222

Work Order No. 518057

File No. 1304758.00003



SUPERIOR COURT OF NEW  
JERSEY  
LAW DIVISION:  
GLOUCESTER COUNTY

Plaintiff  
ATLANTIC ER PHYSICIANS TEAM PEDIATRIC ASSOCIATES, PA, ET AL

vs  
Defendant  
UNITEDHEALTH GROUP, INC., ET AL

DOCKET NO. GLO-L-001196-20

**AFFIDAVIT OF SERVICE**  
(for use by Private Service)

Person to be served: OXFORD HEALTH PLANS NJ, INC.  
F/K/A UNITEDHEALTHCARE OF NEW JERSEY, INC. C/O  
CORPORATION TRUST COMPANY, REGISTERED AGENT  
Address:  
820 BEAR TAVERN ROAD  
TRENTON NJ 08628

Cost of Service pursuant to R4:4-30

\$ \_\_\_\_\_

Attorney:  
K&L GATES LLP  
ONE NEWARK CENTER 10TH FLOOR  
NEWARK NJ 07102

**Papers Served:**

SUMMONS, COMPLAINT & CASE INFORMATION STATEMENT TRACK ASSIGNMENT NOTICE

**Service Data:**

Served Successfully ☒ Not Served \_\_\_\_\_ Date: 11-23-2020 Time: 10:48 a.m. Attempts: \_\_\_\_\_

\_\_\_\_\_ Delivered a copy to him/her personally

Name of Person Served and relationship/title

\_\_\_\_\_ Left a copy with a competent household  
member over 14 years of age residing therein at place of abode.

Scott Kuntz

☒ Left a copy with a person authorized to accept  
service, e.g. managing agent, registered agent, etc.

PERSON IN CHARGE AT THE OFFICE  
OF THE REGISTERED AGENT OF  
THE CORPORATION.

**Description of Person Accepting Service:**

Age: 34 Height: 5'7 Weight: 220 Hair: Black Sex: Male Race: Cauc

**Non-Served:**

- ( ) Defendant is unknown at the address furnished by the attorney  
( ) All reasonable inquiries suggest defendant moved to an undetermined address  
( ) No such street in municipality  
( ) No response on: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

( ) Other: \_\_\_\_\_ Comments or Remarks \_\_\_\_\_

Subscribed and Sworn to me this

24th day of Nov 2020

I, AZIZA AMER, was at  
time of service a competent adult not having a direct  
interest in the litigation. I declare under penalty  
of perjury that the foregoing is true and correct.

Patricia Knapp

Notary Signature

Aziza Amer 11-24-2020

Signature of Process Server

Date

PATRICIA KNAPP  
NOTARY PUBLIC OF NEW JERSEY  
My Commission Expires 6/25/2024

DGR LEGAL, INC.  
1359 Littleton Road, Morris Plains, NJ 07950-3000  
(973) 403-1700 Fax (973) 403-9222

Work Order No. 518255

File No. 1304758.00003

# Exhibit 27

**UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF FLORIDA**

Case No.: 0:20-cv-60757-WPD

FLORIDA EMERGENCY PHYSICIANS  
KANG & ASSOCIATES, M.D., INC.;  
INPHYNET CONTRACTING SERVICES, LLC;  
INPHYNET SOUTH BROWARD, LLC;  
PARAGON CONTRACTING SERVICES, LLC;  
PARAGON EMERGENCY SERVICES, LLC;  
SOUTHWEST FLORIDA EMERGENCY  
MANAGEMENT, LLC; and EMERGENCY  
SERVICES OF ZEPHYRHILLS, P.A.,

*Plaintiffs,*

v.

UNITED HEALTHCARE OF FLORIDA, INC.,  
UNITEDHEALTHCARE INSURANCE CO.,  
UMR, INC., and MULTIPLAN, INC.,

*Defendants.*

---

**AMENDED COMPLAINT**

Plaintiffs, Florida Emergency Physicians Kang & Associates, M.D., Inc. (“FEP”); InPhyNet Contracting Services, LLC (“ICS”); InPhyNet South Broward, LLC (“ISB”); Paragon Contracting Services, LLC (“PCS”); Paragon Emergency Services, LLC (“PES”); Southwest Florida Emergency Management, LLC (“SFEM”); and Emergency Services of Zephyrhills, P.A. (“ESZ”) (collectively, “Plaintiffs” or “Physicians”), by and through undersigned counsel, hereby sue Defendants United Healthcare of Florida, Inc. (“United HMO”); UnitedHealthcare Insurance Co. (“United PPO”); UMR, Inc. (“UMR”); and MultiPlan, Inc. (“MultiPlan”) (collectively, “Defendants”). Collectively, “United HMO,” “United PPO”, and “UMR” are referred to herein as “United.” In support of thereof, Plaintiffs allege as follows:

## **INTRODUCTION**

1. Plaintiffs are providers of emergency medical services. Plaintiffs' physicians and advanced practice nurses staff hospital emergency rooms throughout Florida, where they provide lifesaving medical care to patients, regardless of their ability to pay, including those suffering from COVID-19. This action arises out of a fraudulent scheme among Defendants to deprive Plaintiffs of the full payment Plaintiffs are owed for the emergency medical care they have rendered to patients in Florida insured by United or by an employer-funded health plan for which United serves as a third-party administrator.

2. At all times material to this action, Plaintiffs have not had a written contract with United that establishes the rates of reimbursement they are owed for the emergency services Plaintiffs render to United's members (the "Members"). As such, Florida law provides that Plaintiffs are entitled to reimbursement at a rate equivalent to the lesser of their billed charges or the usual and customary charges for the Plaintiffs' services.

3. At all times material hereto, United has failed to reimburse Plaintiffs at either their billed charges or the usual and customary charges for Plaintiffs' services, in violation of Florida law. Instead, United has dramatically underpaid Plaintiffs for their services.

4. Meanwhile, in an attempt to deceive Plaintiffs into acquiescing to the extraordinarily deficient reimbursement rates United has paid Plaintiffs, United has conspired with Defendant MultiPlan, Inc. to corruptly cloak its inadequate reimbursements in a false veneer of objectivity and reasonableness. United claims to reimburse Plaintiffs in accordance with purportedly objective, allegedly fact-based calculations of usual and customary reimbursement rates generated and supplied to it by MultiPlan through MultiPlan's Data iSight "service." In fact, United's payments to Plaintiffs have no such independent and objective basis. The reimbursement

rates United purports to “receive” from MultiPlan are in fact rates that United has ***directed*** MultiPlan to “suggest” to United. Through this scheme, MultiPlan functions as a willing conduit through which United endeavors to launder its deficient reimbursements in a façade of legitimacy in order to deceive healthcare providers, such as Plaintiffs, into accepting United’s out-of-network reimbursements as being reasonable and representative of the usual and customary charges in the market for the services healthcare providers like Physicians render.

5. Through their fraudulent scheme, Defendants have violated the Racketeering Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961, *et seq.*, and MultiPlan has violated the Florida Deceptive and Unfair Trade Practices Act (FDUTPA), Fla. Stat. §§ 501.201, *et seq.*

6. The reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products) for emergency medical services rendered to United’s Members, (b) that were adjudicated as covered, and allowed as payable by United, (c) at rates below the billed charges and the usual and customary provider charges for similar services in the community where Plaintiffs rendered such services to United’s Members. These claims are collectively referred to herein as the “Claims.”

7. Through this action, Plaintiffs seek treble damages arising from United’s underpayments to the Physicians of the emergency services provided to United’s Members.

8. In addition to their damages, the Physicians also request an order from the Court declaring the rate at which Florida law requires United to pay the Physicians for their emergency services, and a mandatory injunction or declaration compelling United to pay the Physicians at such rates for the out-of-network emergency services the Physicians render to United’s Members in the future.

9. This lawsuit and the claims asserted herein do not relate to or involve the Physicians' right to payment, but rather the applicable rate of payment the Physicians are entitled to receive for their services. This action does not include any claims in which benefits were denied nor does it challenge any coverage determinations under any health plan that may be subject to the Employee Retirement Income Security Act of 1974.

10. This lawsuit further does not include any government-sponsored products, such as Medicare Advantage and managed Medicaid. Those products are not at issue in this litigation, which arises only from claims involving United's commercial plans and products. Without limitation, Physicians specifically exclude from this lawsuit any service provided to patients 65 years of age or older as of the date services were rendered.

### **PARTIES**

11. Plaintiff FEP is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. FEP has not been a participating provider within United's provider network since January 15, 2020.

12. Plaintiff ICS is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ICS has not been a participating provider within United's provider network since October 15, 2019.

13. Plaintiff ISB is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ISB has not been a participating provider within United's provider network since October 15, 2019.

14. Plaintiff PCS is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. PCS has not been a participating provider within United's provider network since January 15, 2020.

15. Plaintiff PES is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. PES has not been a participating provider within United's provider network since October 15, 2019.

16. Plaintiff SFEM is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. SFEM has not been a participating provider within United's provider network since January 15, 2020.

17. Plaintiff ESZ is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ESZ has not been a participating provider within United's provider network since January 15, 2020.

18. Upon information and belief, Defendant United HMO is a Florida for-profit corporation with its principal place of business in Hillsborough County, Florida. United HMO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a health maintenance organization ("HMO") in Florida under Fla. Stat. § 641.17, et seq.

19. Upon information and belief, Defendant United PPO is a foreign for-profit corporation with its principal place of business in Hartford, Connecticut. As a preferred provider organization, United PPO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a life and health insurer in Florida under Fla. Stat. § 624.01, et seq.

20. Upon information and belief, Defendant UMR is a foreign for-profit corporation with its principal place of business in Wausau, Wisconsin. UMR operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a third-party administrator in Florida under Fla. Stat. § 624.01, et seq.



21. Upon information and belief, Defendant MultiPlan is a foreign for-profit corporation with its principal place of business in New York, New York. MultiPlan is not a health insurer nor is MultiPlan regulated by the Florida Office of Insurance Regulation.

### **JURISDICTION AND VENUE**

22. This Court has jurisdiction over the federal claims for relief alleged in Counts I, II, and IX pursuant to 18 U.S.C. §§ 1961, 1962, 1964 and/or 28 U.S.C. § 1331.

23. This Court has the authority to grant declaratory relief under 28 U.S.C. §§ 2201 and 2202 because there is an actual controversy between the Physicians and Defendants.

24. This Court has supplemental jurisdiction pursuant to 28 U.S.C. § 1367 and the doctrine of pendent jurisdiction over the state law claims asserted herein.

25. Venue is proper in this District pursuant to 18 U.S.C. § 1965 and 28 U.S.C. § 1391(b)(2) because a substantial part of the events giving rise to the claims asserted herein occurred in this District and because the Defendants conduct business in this District.

### **FACTS**

#### ***The Physicians Are Out-of-Network Providers***

26. At all times material hereto, the Physicians have not been participating providers with United.

27. All of the Claims at issue in this action are for reimbursement for services the Physicians provided at times when they were non-participating (or “out-of-network”) providers with United.

28. Despite their out-of-network status, the Physicians have provided medically necessary, covered services to United’s Members.

29. At all times material to this action, the Physicians have not agreed to accept any form of discounted rate from United or to be bound by United's payment policies or rate schedules with respect to any of the health care services provided by the Physicians to United's Members. Notwithstanding the absence of any such agreement, at all times material, United has unilaterally applied an unlawful discount to its payments to the Physicians for the Physicians' emergency services.

30. At all times material to this action, United has paid for the emergency services the Physicians have rendered to United's Members, but at rates less than the Physicians are entitled to receive by law. United has made unlawful discounted payments to the Physicians for the emergency services the Physicians have rendered to United's Members, and the unlawfully underpaid Claims continue to accrue.

31. Even though the Physicians are out-of-network providers, and, therefore, have not agreed to accept discounted reimbursement rates from United, United has reimbursed the Physicians for emergency services rendered to United's Members at rates that are substantially less than the rates United previously paid, and the Physicians previously accepted, for the same emergency services prior to United's termination of the participating provider agreements between the parties.

***United's Failure to Reimburse the Physicians in Accordance with Florida Law***

32. Section 641.513(5), Florida Statutes, which is part of Florida's HMO Act, provides that reimbursement for emergency services by providers such as the Physicians "who do[] not have a contract with the [HMO] shall be the lesser of: (a) The provider's charges; (b) The usual and customary provider charges for similar services in the community where the services were

provided; or (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.”

33. Section 627.64194, Florida Statutes, requires insurers to reimburse out-of-network health care providers, such as Plaintiffs, for emergency services that such providers render to the insurer’s PPO/POS members in accordance with the provisions of Fla. Stat. § 641.513(5). See Fla. Stat. § 627.64194(4) (“An insurer must reimburse a nonparticipating provider of services under subsections (2) and (3) as specified in s. 641.513(5), reduced only by insured cost share responsibilities as specified in the health insurance policy, within the applicable timeframe provided in s. 627.6131.”).

34. The Physicians have not reached agreement with United regarding any charges within sixty (60) days of the submittal of the Claims at issue in this action.

35. For the Claims at issue in this action, United has underpaid the Physicians by reimbursing the Physicians substantially less than the Physicians’ charges and the “usual and customary provider charges for similar services in the community where the services were provided.”

36. United’s refusal to lawfully pay the Physicians for the emergency services the Physicians have provided to United’s Members has caused, and continues to cause, the Physicians to suffer damages, which are ongoing in nature.

37. The Physicians are entitled to interest on the amounts overdue on the underpaid Claims.

38. As a result of United’s violations of Florida law, the Physicians have suffered damages.

***The Physicians Have No Recourse for United's Underpayments Except Against United***

39. Under Florida law, the Physicians are precluded from seeking payment from patients for the difference between the amounts allowed as reimbursement by United and the lesser of the Physicians' charges or the usual and customary charges in the community for the services provided. See Fla. Stat. §§ 641.3154, 627.64194.

40. Indeed, to this end, the remittance advice documents ("RAs") the Physicians receive from United accompanying United's underpayments of the Claims instruct the Physicians not to bill patients for any amounts beyond the amount of the deductible, copay, and coinsurance applied to the service. These documents explain United's payment in pertinent part as follows: "PROVIDER: DON'T BILL THE PATIENT ABOVE THE AMOUNT OF THE DEDUCTIBLE, COPAY, AND COINSURANCE APPLIED TO THIS SERVICE." The RAs United generates and remits to the Physicians further identify the "Patient Responsibility" for the Physicians' services as only encompassing applicable deductibles, copays, or coinsurance amounts. That is, United advises the Physicians that their Members are not liable for the differential between the Physicians' billed charges and the amounts allowed as payable by United.

41. It is extraordinarily inequitable and unjust for United to fail to reimburse the Physicians at the fair value of the emergency services they rendered to United's Members.

42. At all times material, the Physicians billed United for their Claims arising from the treatment of United's Members. The Physicians did so with the expectation of appropriate reimbursement at no less than the Physicians' charges or the usual and customary charges for the Physicians' services, as required by statute, and United's implied agreement to reimburse the Physicians for the emergency medical care rendered at no less than the Physicians' charges or the usual and customary charges for the Physicians' services.

43. United knew the Physicians expected payment for the emergency medical care they provided. United and the Physicians have demonstrated their mutual agreement and understanding that United would reimburse the Physicians at their billed charges or at a usual and customary rate. By assuming responsibility for paying for the emergency medical care provided to United's Members, United impliedly agreed to reimburse the Physicians at either their charges or the usual and customary provider charges.

44. United consistently (a) adjudicated the Claims as covered and medically necessary and (b) paid the Physicians for the Claims. However, at all times material, United's payments made for services rendered to Members in both fully-funded and employer-funded plans have been below both the Physicians' charges and the usual and customary provider charges for similar services in the community where the services were rendered.

45. United accepted and enjoyed the benefit of the Physicians' valuable services.

46. United's refusal to appropriately pay the Physicians for the emergency medical care provided to United's Members has caused, and continues to cause, the Physicians to suffer damages in an amount equal to the difference between the amounts paid by United and the lesser of the Physicians' charges or the usual and customary provider charges for the emergency services Physicians rendered, plus the loss of use of that money.

47. United's underpayment of the Claims violates the duty they owe to the Physicians.

48. United continues to underpay the Physicians for covered services rendered to their members. The Physicians therefore seek a declaration establishing the appropriate reimbursement rates to be paid going forward, in order to avoid further harm.

***The Relationship Between the Physicians and United***

49. In exchange for premiums, fees, and/or other compensation, United assumes responsibility for paying for health care services rendered to members covered by their health plans.

50. In addition, United provides services such as building participating provider networks and negotiating rates with providers who join their networks.

51. United offers a range of health insurance plans. Plans generally fall into one of two categories: Fully Funded plans and Employer Funded plans.

52. “Fully Funded” plans are plans in which United collects premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums. “Employer Funded” plans are plans in which United provides administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant’s employer.

53. United provides coverage for emergency medical services under both types of plans.

54. United is contractually and legally responsible for ensuring that its members can receive such services (a) without obtaining prior approval and (b) without regard to the “in network” or “out-of-network” status of the emergency services provider.

55. United highlights such coverage in marketing its insurance products, inducing members to purchase their products and rely upon those representations.

56. For example, on the “patient protections” section of the UnitedHealthcare website, [uhc.com](http://uhc.com), United states:

There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network

provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

57. Payors, like United, typically demand a lower payment rate from contracted participating providers.

58. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

59. United bears responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

60. United understands and expressly acknowledges that their members will seek emergency treatment from non-participating providers and that United is obligated to pay for those services.

***The Reasonable Rate for Non-Participating Emergency Services is Well Established***

61. For many years, United has allowed payment at 75-90% of billed charges for out-of-network emergency services.

62. United has done so largely through the use of “rental networks,” including those offered by MultiPlan, which establish a reasonable rate for provider services through arms'-length negotiations between the rental network and providers, on the one hand, and the rental network and health insurance companies, on the other.

63. Rental networks act as “brokers” between non-participating providers and health insurance companies.

64. A rental network will secure a contract with a provider to discount its out-of-network charges.

65. The rental network then contracts with (or “rents” its network to) health insurance companies to allow the insurer access to the rental network and to the providers’ agreed-upon discounted rates.

66. As such, rental networks’ negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

67. For many years, the Physicians’ contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Physicians’ billed charges for claims adjudicated through the rental network agreement.

68. This longstanding history establishes that a reasonable reimbursement rate for the Physicians’ Claims for emergency services is 75-90% of the Physicians’ billed charge.

69. Despite this history, since terminating the network agreements with Plaintiffs, United has slashed their reimbursement rate for Claims to less than half the reasonable reimbursement rate.

70. United’s drastic payment cuts are entirely inconsistent with the established rate and parties’ history.

***United’s History of Fraudulently Manipulating Out-of-Network Reimbursement Rates***

71. United has a history of fraudulently manipulating reimbursement rates for non-participating providers to maximize its own profits at the expense of others, including their own members.

72. In 2009, UnitedHealth Group, Inc., an affiliate of the United Defendants, was investigated by the New York State Attorney General’s Office for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.



73. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

74. Andrew Cuomo, then New York Attorney General, explained of United's scheme: "The lack of accuracy, transparency, and independence surrounding United's process for setting a 'reasonable and customary rate' is astounding. United's ownership of Ingenix coupled with the inherent problems with the data it is using clearly demonstrate a broken reimbursement system designed to rip off patients and steer them towards in-network-doctors that cost the insurer less money." See "Cuomo Announces Industry-wide Investigation Into Health Insurers; Fraudulent Reimbursement Scheme" (Feb. 13, 2008), available at <https://ag.ny.gov/press-release/2008/cuomo-announces-industry-wide-investigation-health-insurers-fraudulent>.

75. Like Data iSight here, Ingenix "serve[d] as a conduit for rigged data to the largest insurers in the country." *Id.* Of particular concern was the fact that United's "ownership of Ingenix created a clear conflict of interest because their relationship gave Ingenix an incentive to set rates that benefited United and its subsidiaries." *Id.*

76. UnitedHealth Group, Inc. ultimately paid a \$50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark. Also in 2009, United HealthCare Insurance Co. and affiliates thereof, paid \$350 million to settle class action claims alleging that they underpaid non-participating providers for services arising out of the same conduct in *American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

77. In announcing its settlement with United, the New York Attorney General explained, "[f]or the past ten years, American patients have suffered from unfair reimbursements

for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry.” See “Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars” (Jan. 13, 2009), *available at* <https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends>.

78. The New York Attorney General declared that the settlement would “end conflicts of interest” in United’s determinations of the “usual and customary” rate. *Id.* Or so he thought.

79. Through MultiPlan and Data iSight, United has endeavored to revive the same fraudulent scheme that the New York Attorney General shut down a decade ago.

***FAIR Health Affords Payers and Providers a Database of Usual and Customary Rates***

80. Since its inception, FAIR Health’s benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers. For example, numerous states recognize FAIR Health’s database as an official source for healthcare cost data to determine reimbursement for non-participating providers’ emergency services.

81. United purports to use FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website. United represents that where payment for out-of-network services is to be made the usual and customary rate, United “most commonly refer[s] to a schedule of charges created by FAIR Health, Inc. (‘FAIR Health’) to determine the amount of the payment.” See “Information on Payment of Out-of-Network Benefits,” *available at* <https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits>.

82. As United recognizes, a usual and customary rate is “base[d] . . . on what other healthcare professionals in a geographic area charge for their services.” *Id.*

83. While United publicly gives the appearance of holding itself to independent benchmarks to set reimbursement rates, in fact, United has shirked its responsibility to reimburse the Physicians at the usual and customary rate by conspiring with MultiPlan to — yet again — manipulate and depress reimbursements for out-of-network services.

***RICO Defendants’ Fraudulent Scheme to Deprive the Physicians of Reasonable Reimbursement Violated the Racketeer Influenced and Corrupt Organizations Act (RICO)***

84. Defendants violated the Racketeering Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961, *et seq.*, and in particular, 18 U.S.C. §§ 1962(c)-(d).

85. The Defendants conducted and participated directly or indirectly in the affairs of an association-in-fact enterprise (“the Enterprise”) through a scheme that formed a pattern of racketeering activity.

86. Each of the Defendants agreed to join the Enterprise with knowledge of the Enterprise’s unlawful goals and purposes and to commit acts in furtherance of the Enterprise’s common purpose.

87. Each of the Defendants committed the various acts in furtherance of the Enterprise’s common unlawful purpose that the Defendants are described to have committed herein.

88. As part of this scheme, the Defendants conspired to, and did knowingly and unlawfully, reduce the Physicians’ reimbursement rates for the Claims to amounts significantly below the Physicians’ charges and the usual and customary charges for services rendered to Defendants’ members to the detriment of the Physicians, to the benefit and financial gain of Defendants, and in violation of Florida law.

89. To carry out the scheme and in furtherance of the conspiracy, Defendants engaged in conduct that violated federal laws, including, *inter alia*, mail fraud in violation of 18 U.S.C. § 1341, and wire fraud in violation of 18 U.S.C. § 1343.

90. As a result of the scheme, RICO Defendants violated 18 U.S.C. §§ 1962(c)-(d).

***Defendants' Activities Constitute a Pattern of Unlawful Racketeering Activity***

91. Defendants have committed, and continue to commit, related predicate acts of racketeering activity involving mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, such that they have engaged in a “pattern of racketeering activity” under 18 U.S.C. § 1961(5) and pose a continued threat of racketeering activity, as described below.

92. Defendants have knowingly, wrongfully, and unlawfully reduced payment to the Physicians for the emergency services that the Physicians provided to Defendants' Members, to the financial gain of the Defendants.

93. As a direct and proximate result of those activities, the Physicians have suffered more than \$28 million in discrete financial losses, through March 31, 2020, which damages continue to accrue.

***The Enterprise and Scheme***

94. The Enterprise consists of Defendants' development and use of MultiPlan's Data iSight software in connection with reimbursement determinations by United.

95. Defendants agreed to, and do, manipulate reimbursement rates and control allowed payments to the Physicians through acts of the Enterprise.

96. The Enterprise conceals its scheme by hiding behind written agreements and false statements.

97. Since at least October 15, 2019, the Enterprise has falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates through the use of Data iSight.

98. In reality, United uses Data iSight as a cover-up for United to justify paying reimbursement to the Physicians that is far less than the reasonable payment rate that the Physicians have historically received and are entitled to under the law.

99. This scheme is concealed through the use of false statements on MultiPlan's website, Data iSight's website, and in United's and Data iSight's communications with providers, including the Physicians.

100. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants.

# **(1) The Enterprise's False Statements**

## **a. Transparency**

101. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers] . . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

102. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

103. This concealment was designed by the Enterprise to, and does, prevent providers such as the Physicians from receiving the appropriate payment for the services they provide.

104. For claims whose reimbursement is determined by Data iSight, non-participating providers receive an Explanation of Benefit form (“EOB”) from United with “IS” in the “Remark/Notes” column.

105. Over the past 8 months, an ever-increasing number of Claims have been processed by Data iSight with drastically reduced payment amounts.

106. United does not state, on the face of the EOBs, or anywhere else, any reason for the dramatic cut.

107. Instead, the EOBs contain a note to call a toll-free number at Data iSight if there are questions about the claim.

108. In June 2019, affiliates of the Physicians contacted Data iSight via the toll-free number to discuss two claims for the same procedure code, performed at the same facility, billed at the same amount of \$700, but for which Data iSight allowed different, insufficient reimbursement amounts at 42% and 59% of billed charges (\$295.28 and \$413.39, respectively).

109. After affiliates of the Physicians left messages at Data iSight’s phone number for approximately two weeks, a Data iSight representative, Phina (Last Name Unknown) (“LNU”), finally connected with the Physicians; however, she was unable to explain why the two claims—for the same procedure at the same facility and billed at the same charge—were allowed at different rates.

110. Further, when asked to provide the basis for the dramatic cut in payment for the claims, the representative did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all.

111. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

112. Instead, the representative simply stated that the rates were developed by Data iSight and United.

113. When affiliates of the Physicians continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that “it is just an amount that is recommended and sent over to United.”

114. When James LNU was expressly challenged on Data iSight’s false claim that it is transparent with providers, he responded with silence.

115. Further attempts to gain transparency into and understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight’s executives have also been futile.

116. Defendants know that the rates that Defendants, through Data iSight, have allowed for the Physicians’ Claims do not reflect and are not, in fact, based on objective, reliable data designed to arrive at the usual and customary rates for the services in question.

117. Defendants know that the initial reimbursement rates they allow are insufficient because, when a provider challenges the rate of payment, United authorizes Data iSight to revise the allowed amount by increasing it to a fair, usual and customary rate, but only if the provider persists long enough in the process.

118. The process to contest the arbitrary and deficient payments takes the provider weeks to conclude and is impracticable to follow for every claim — precisely by Defendants’ design.

119. For example, and as evidence of this fraudulent practice, affiliates of the Physicians contested the allowed amounts on the two claims discussed above.

120. Eventually, Carol LNU from Data iSight's "Quality Control" team offered to allow payment of both claims at 85% of their respective billed charges.

121. Thus, absent providers taking the time to individually chase every claim, Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the provider's charges and the usual and customary charges for such services.

122. Moreover, the Enterprise's scheme of refusing to reimburse at usual and customary rates unless and until the Physicians challenge its determinations continually harms the Physicians, in that, even if the Physicians eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens the Physicians with excessive administrative time and expense and deprives the Physicians of their right to prompt payment of clean claims under Florida's Prompt Payment Statute.

**b. Defensible and Market Tested**

123. The Enterprise's claim to "transparency" is not its only fraudulent claim.

124. The Enterprise, through Data iSight, also falsely claims, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

125. EOBs for claims processed purportedly pursuant to Data iSight contain the following or a similar note: "Calculated using Data iSight, which utilizes cost data if available (facilities) or paid data (professionals)."

126. United further advises as follows in EOBs for many of the claims paid purportedly pursuant to Data iSight:

In order to help save you and the plan money, [United] uses a service called Data iSight to review select out-of-network claims and recommend a reduced payment



amount for out-of-network covered services. . . . Based on the Data iSight review, the recommended amount for the covered services provided is shown on your explanation of benefits (EOB). Your provider will be informed of that recommendation.

127. These notes are intended to, and do, lead providers to believe that the reimbursement calculations are tied to external, objective data.

128. Further, in its provider portal, the Data iSight website describes its “methodology” for reimbursement determinations as “calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor.”

129. MultiPlan similarly describes Data iSight’s process as using “cost- and reimbursement-based methodologies” and asserts that it has been “[v]alidated by statisticians as effective and fair.”

130. These statements are also false.

131. Data iSight’s rates are not effective and fair. Instead, they are artificially low and match the rates United has directed MultiPlan to determine using the Data iSight tool. United and MultiPlan know that these rates are not reflective of fair market value.

132. Furthermore, contrary to its portrayal, Data iSight’s rates are unfair because, on belief, MultiPlan is financially incentivized to generate rates that are as low as possible through its contracts with United, rather than rates that accurately reflect the usual and customary charges in the community for the services rendered.

133. For example, over a period of four months in 2020, the Physicians submitted claims for three patients under the procedure code 99285, but received reimbursement in very different allowed amounts:

134. Plaintiff ISB rendered emergency medical care to patient MV on January 3, 2020, and billed United \$1,816.00 for procedure code 99285. United, via Data iSight, allowed just 24% of billed charges, or \$436.58. Likewise, for patient BT, ISB rendered emergency medical care on January 9, 2020, and billed United \$1,816.00 for procedure code 99285. United, via Data iSight, also allowed just 24% of charges, or \$436.58.

135. But for patient LU, Plaintiff ISB rendered emergency medical care on January 2, 2020, and billed United \$1,816.00 for procedure code 99285. United, via Data iSight, initially allowed only 34% of billed charges, or \$611.21. ISB objected to the deficient payment and United subsequently allowed 90% of billed charges, or \$1,634.40 as payment.

136. And for patient IP, Plaintiff ISB rendered emergency medical care on February 1, 2020, and billed United \$1,816.00 for procedure code 99285. United, via Data iSight, allowed 100% of billed charges as payment.

| PATIENT | DATE OF SERVICE | PROCEDURE CODE | BILLED AMOUNT | ALLOWED AMOUNT | ALLOWED AMOUNT (%) |
|---------|-----------------|----------------|---------------|----------------|--------------------|
| MV      | 1/3/2020        | 99285          | \$1,816.00    | \$436.58       | 24%                |
| BT      | 1/9/2020        | 99285          | \$1,816.00    | \$436.58       | 24%                |
| LU      | 1/2/2020        | 99285          | \$1,816.00    | \$1,634.40*    | 90%                |
| IP      | 2/1/2020        | 99285          | \$1,816.00    | \$1,816.00     | 100%               |

137. From the above examples, it is clear that MultiPlan's Data iSight service does not use any objective, externally-validated methodology to determine the usual and customary reimbursement rate, as its rates are not consistent, defensible, or reasonable.

138. Additionally, it is clear that United and Data iSight know that amounts determined in arm's length transactions and freely negotiated, result in payments of 90-100% of the Physicians' billed charges, rather than the artificially low amount initially offered.

139. Defendants’ false assertions are designed to mislead the Physicians and similar providers into believing that they will receive payment at reasonable rates. This reimbursement is dictated by Defendants, to the financial detriment of the Physicians.

**c. Geographic Adjustment**

140. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

141. Indeed, on its provider portal, Data iSight falsely claims that “[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area.”

142. Data iSight’s parent company, MultiPlan, further falsely states on its website that:

For professional claims where actual costs aren’t readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

143. Contrary to those statements, however, claims from providers affiliated with Plaintiffs in different geographic locations show that Data iSight does not adjust for geographic differences but, instead, works with United to cut uniformly out-of-network provider payments across geographic locations.

144. For example, patient WY was treated in Wyoming on January 21, 2019 by an affiliate of Plaintiffs. The provider billed a United affiliate \$779.00 for procedure code 99284, and the United affiliate, via Data iSight, allowed \$413.39.

145. Four days later, patient NH was treated on the other side of the country in New Hampshire by an affiliate of Plaintiffs. The provider billed a United affiliate \$1,047.00 for procedure 99284, and the United affiliate, via Data iSight, again allowed \$413.39.

146. On February 8, 2019, patient OK was treated by an affiliate of Plaintiffs in Oklahoma. The provider billed a United affiliate \$990.00 for procedure code 99284, and the United affiliate, via Data iSight, allowed \$413.39.

147. Two days later, patients KS and NM were by affiliates of Plaintiffs treated in Kansas and New Mexico, respectively. The providers billed a United affiliate \$778.00 and \$895.00, respectively, for procedure code 99284, but for both of these claims, United, via Data iSight, allowed exactly \$413.39.

148. One month later, patient CA was treated by an affiliate of Plaintiffs in California. The provider billed a United affiliate \$937.00 for procedure code 99284. The United affiliate, via Data iSight, yet again allowed exactly \$413.39.

149. In May 2019, patient NY was treated by an affiliate of Plaintiffs in New York. The provider billed \$806.00 for procedure code 99284. The United affiliate, via Data iSight, again allowed exactly \$413.39.

150. And in November 2019, patient FL was treated by Plaintiff ICS in Florida. ICS billed \$1,502 for procedure code 99284. United, yet again, allowed exactly \$413.39.

| PATIENT | LOCATION      | DATE OF SERVICE | BILLED AMOUNT | PROCEDURE CODE | ALLOWED AMOUNT |
|---------|---------------|-----------------|---------------|----------------|----------------|
| WY      | Wyoming       | 1/21/19         | \$779.00      | 99284          | \$413.39       |
| NH      | New Hampshire | 1/25/19         | \$1,047.00    | 99284          | \$413.39       |
| OK      | Oklahoma      | 2/8/19          | \$990.00      | 99284          | \$413.39       |
| KS      | Kansas        | 2/10/19         | \$778.00      | 99284          | \$413.39       |
| NM      | New Mexico    | 2/10/19         | \$895.00      | 99284          | \$413.39       |
| CA      | California    | 3/25/19         | \$937.00      | 99284          | \$413.39       |
| NY      | New York      | 5/19/19         | \$806.00      | 99284          | \$413.39       |

FL Florida 11/02/19 \$1,502.00 99284 \$413.39

151. United falsely claims on its website to “frequently use” the 80th percentile of the FAIR Health Benchmark databases “to calculate how much to pay for out-of-network services.”

152. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but would also all be substantially greater than the allowed \$413.39, examples of which are set forth below:

| LOCATION      | PROCEDURE CODE | 80th PERCENTILE OF FAIR HEALTH BENCHMARK <sup>1</sup> |
|---------------|----------------|-------------------------------------------------------|
| Florida       | 99284          | \$1,422.00                                            |
| Wyoming       | 99284          | \$1,105.00                                            |
| New Hampshire | 99284          | \$753.00                                              |
| Oklahoma      | 99284          | \$1,076.00                                            |
| Kansas        | 99284          | \$997.00                                              |
| New Mexico    | 99284          | \$1,353.00                                            |
| California    | 99284          | \$795.00                                              |
| New York      | 99284          | \$768.00                                              |

## (2) The Enterprise’s Predicate Acts

153. To perpetuate the scheme and conceal it from the Physicians, in or around 2018, Defendants entered into written agreements with each other that are consistent with MultiPlan’s agreements with similar health insurance companies.

154. Under those contracts, MultiPlan, through Data iSight, would handle claims determinations for services rendered to United’s members under pre-agreed thresholds set by United.

<sup>1</sup> The benchmark figures listed in this table are the applicable 80th-percentile rates for the relevant geographic market within each state in which the referenced patient received medical treatment. For example, the \$1422 rate for the patient from Florida is the FAIR Health benchmark rate for Florida geozip 03.

155. By no later than 2019, Defendants coordinated and effectuated, via wire communications, the posting of false statements on websites and the communication of false statements to providers, including the Physicians, in furtherance of the scheme.

156. These statements include MultiPlan's using interstate wires to post, on its websites and the website for Data iSight, that it would provide transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment processes for providers.

157. Data iSight communicated to affiliates of the Physicians by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United."

158. Finally, after weeks of pressure, Data iSight informed the Physicians by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

159. The Enterprise communicated, via wire communications, false and misleading information to the Physicians and falsely denied that it had information requested by the Physicians about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

160. In addition, since at least October 15, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Physicians by means of the United States Postal Service and interstate wires at unlawful rates that were far below reasonable rates for the services provided.

161. For example, United sent the Physicians, via wire communications, EOBs for emergency services provided to patients under multiple procedure codes, including the following EOBs for procedure code 99285:

162. Patient TH was treated by Plaintiff ICS on November 15, 2019, at a billed charge of \$2,147.00, for which United, via Data iSight, allowed just \$435.20, or 20% of the billed charges. United sent the EOB for this claim via wire communication on February 5, 2020.

163. Patient EH was treated on December 9, 2019 by Plaintiff ISB at a billed charge of \$1,816.00, for which United, via Data iSight, allowed just \$435.20, or 24% of charges. United sent the EOB for this claim via wire communication on January 15, 2020.

164. Patient KG was treated on November 17, 2019 by Plaintiff PES, at a billed charge of \$1,824.00, for which United, via Data iSight, initially allowed just \$609.28, or 33% of charges. United sent the EOB for this claim via wire communication on January 23, 2020. After the Plaintiff objected to the deficient payment, United, via Data iSight, subsequently allowed \$1,641.60 as payment, or 90% of charges.

| PATIENT | DATE OF SERVICE | BILLED AMOUNT | PROCEDURE CODE | ALLOWED AMOUNT | ALLOWED AMOUNT (%) |
|---------|-----------------|---------------|----------------|----------------|--------------------|
| TH      | 11/15/19        | \$2,147.00    | 99285          | \$435.20       | 20%                |
| EH      | 12/09/19        | \$1,816.00    | 99285          | \$435.20       | 24%                |
| KG      | 11/17/19        | \$1,824.00    | 99285          | \$1,641.60     | 90%                |

165. Defendants expected that those unreasonable payments would be accepted in full satisfaction of the Physicians' claims.

166. Defendants have received, and continue to receive, financial gains from their scheme to defraud the Physicians.

167. The purpose and direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse the Physicians at deficient rates, to the harm of the Physicians, and to the benefit of the Enterprise.

168. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

**COUNT I**  
**Violation of RICO, 18 U.S.C. § 1962(c)**  
**(as against all Defendants)**

169. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

170. The Physicians are each a “person” within the meaning of 18 U.S.C. §§ 1961(3) and 1964(c).

171. Defendants are each a “person” within the meaning of 18 U.S.C. § 1961(3).

172. As set forth above, since at least October 15, 2019, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least Defendants, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

173. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

174. Defendants had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding the Physicians and preventing the Physicians from obtaining payment for the services they provided to Defendants’ Members at no less than the Physicians’ charges or the usual and customary rate for the Physicians’ services.



175. As set forth above, the Defendants since at least October 15, 2019, have been, and continue to be, engaged in a scheme to defraud the Physicians by committing a series of unlawful acts which constitute predicate racketeering acts under 18 U.S.C. §§ 1961(1)(B) and 1962(c), involving multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343.

176. Each Defendant provides benefits to insured Members, processes claims for services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services, and knowingly and willingly participates in the scheme to defraud the Physicians.

177. As a direct and proximate result of Defendants' violations of 18 U.S.C. § 1962(c), the Physicians were injured in their business, suffering financial losses within the meaning of 18 U.S.C. § 1964(c).

**COUNT II**  
**Violation of RICO conspiracy, 18 U.S.C. § 1962(d)**  
**(as against all Defendants)**

178. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

179. The Physicians are each a "person" within the meaning of 18 U.S.C. §§ 1961(3) and 1964(c).

180. Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

181. As set forth above, since at least October 15, 2019, Defendants have been, and continue to be, part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least Defendants, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

182. Defendants were, and continue to be, associated with the Enterprise and knowingly conspired, within the meaning of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting and participating, directly or indirectly, in the conduct and affairs in the Enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. §§ 1961(1)(B) and 1962(c), including multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343, in order to defraud the Physicians of a reasonable reimbursement for services.

183. As a direct and proximate result of Defendants' violations of 18 U.S.C. § 1962(d), the Physicians were injured in their business, suffering financial losses within the meaning of 18 U.S.C. § 1964(c).

**COUNT III**  
**Violation of FDUTPA**  
**(as against MultiPlan)**

184. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

185. MultiPlan engages in trade or commerce by advertising, soliciting, providing, offering, or distributing its Data iSight service, which MultiPlan, according to MultiPlan, generates "fair" reimbursement rates for out-of-network services in accordance with objective independent data.

186. The Physicians are consumers of MultiPlan's services. Insofar as United prices a claim utilizing Data iSight, MultiPlan intends for providers to utilize and rely on its recommended reimbursement rates as fair and reasonable reimbursement rates for out-of-network services based on objective data and neutral analyses. The Physicians are thus intended beneficiaries of MultiPlan's out-of-network pricing services. Indeed, Data iSight advertises its services as

benefiting healthcare providers. For example, in a section of its website titled “Transparency for You, the Provider,” MultiPlan describes Data iSight as affording the following benefits to providers: “A key feature of Data iSight is this website, which gives [providers] a better understanding of how these payment amounts are determined. The website makes the process for determining appropriate payment transparent to you so that you may become a more informed healthcare partner, and to assist you with any questions about how this claim was reduced. It also provides the information to the health plan payer and the patient so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated.”

187. Furthermore, the Physicians are consumers of MultiPlan’s rental network services through which MultiPlan serves as a broker between non-participating providers, such as the Physicians, and health insurance companies, such as United.

188. MultiPlan’s conduct is unfair and deceptive under FDUTPA. The reimbursement rates that MultiPlan, through Data iSight, generates and purportedly recommends to United are not, in fact, fair and reasonable reimbursement rates for out-of-network services reflecting the usual and customary charges for such services in the community. Nor are they based on Data iSight’s independent determinations of objective data as to the usual and customary reimbursements. Rather, the reimbursement rates that MultiPlan purports to recommend to United through Data iSight are rates at which United has instructed MultiPlan to price such claims. MultiPlan thereby knowingly functions as a conduit through which United endeavors to launder its deficient reimbursements in a façade of reasonableness, objectivity, and legitimacy in order to deceive healthcare providers, such as the Physicians, into accepting United’s out-of-network reimbursements as being reasonable and representative of the usual and customary charges in the

market for the services healthcare providers like Physicians render. MultiPlan's conduct is likely to mislead a consumer of its services acting reasonably in the circumstances.

189. Furthermore, contrary to its portrayal, MultiPlan's recommended prices are unfair because, on belief, MultiPlan is financially incentivized to generate rates that are as low as possible through its contracts with United, rather than rates that accurately reflect the usual and customary charges in the community for the services rendered.

190. MultiPlan's conduct has caused Physicians to suffer actual damages. As a direct result of MultiPlan's fraudulent scheme, Physicians have received deficient reimbursements from United on all of the Claims at amounts less than Physicians are entitled to receive. Furthermore, MultiPlan's conduct has harmed the Physicians' contractual relationship with MultiPlan in that they have received less in reimbursement for the Claims than they would otherwise receive if those services had been priced pursuant to MultiPlan's rental network rates, which are rates that Physicians have accepted through their agreements with MultiPlan.

191. MultiPlan has therefore violated FDUTPA, Fla. Stat. § 501.204(1).

**COUNT IV – Violation of Florida Statute § 641.513**  
**(against United HMO)**

192. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

193. At all times material, the Physicians and United HMO have not had a written contract between them governing the rates at which United HMO must reimburse the Physicians for emergency services provided to United HMO's Members.

194. At all times material, the Physicians have not been a participating provider in United HMO's provider network; therefore, the Physicians have been out-of-network providers.

195. At all times material, the Physicians have rendered emergency services to United HMO's Members. All such services have been medically necessary, covered services.

196. All of the claims at issue in this count are for services rendered to persons who have contracted, or on whose behalf a contract has been entered into, with United HMO for health care services.

197. Section 641.513(5), Florida Statutes, provides that all HMOs, such as United HMO, must reimburse non-participating providers for emergency services in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or "[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

198. The Physicians have not reached agreement with United HMO regarding any charges within sixty (60) days of the submittal of the claims at issue in this action. Therefore, under Florida law, the Physicians are entitled to reimbursement at the lesser of their charges or (if hypothetically different) the "usual and customary provider charges for similar services in the community where the services were provided."

199. United HMO has reimbursed the Physicians for the emergency services they have rendered to United HMO's Members at all times material at substantially less than the Physicians' charges.

200. United HMO has reimbursed the Physicians for the emergency services they have rendered to United HMO's Members at all times material at substantially less than the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United HMO's Members.

201. Accordingly, United HMO has failed to reimburse the Physicians for the emergency services the Physicians rendered to United HMO's Members in accordance with Fla. Stat. § 641.513(5). United HMO has therefore violated Fla. Stat. § 641.513(5).

**COUNT V – Violation of Florida Statute § 627.64194**  
**(United PPO)**

202. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

203. At all times material, the Physicians and United PPO have not had a written contract between them governing the rates at which United PPO must reimburse the Physicians for emergency services provided to United PPO's Members.

204. At all times material, the Physicians have not been a participating provider in United's PPO provider network; therefore, the Physicians have been out-of-network providers.

205. At all times material, the Physicians have rendered emergency services to United PPO's Members. All such services have been medically necessary, covered services.

206. All of the claims at issue in this count are for services rendered to persons who are covered under a health insurance contract delivered or issued for delivery by United PPO in Florida.

207. Section 627.64194(4), Florida Statutes, requires that all insurers, such as United PPO, reimburse nonparticipating providers, such as Plaintiffs, for both non-emergency services and emergency services rendered to the insurer's members according to the methodology set forth in Fla. Stat. § 641.513(5).

208. Pursuant to Fla. Stat. § 641.513(5), nonparticipating providers are entitled to reimbursement for services rendered in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services

were provided,” or “[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.”

209. The Physicians have not reached agreement with United PPO regarding any charges within sixty (60) days of the submittal of the claims at issue in this action. Therefore, under Florida law, the Physicians are entitled to reimbursement at the lesser of their charges or (if hypothetically different) the “usual and customary provider charges for similar services in the community where the services were provided.”

210. United PPO has reimbursed the Physicians for the emergency services they have rendered to United PPO’s Members at all times material at substantially less than the Physicians’ charges.

211. United PPO has reimbursed the Physicians for the emergency services they have rendered to United PPO’s Members at all times material at substantially less than the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United PPO’s Members.

212. Accordingly, United PPO has failed to reimburse the Physicians for the emergency services the Physicians rendered to United PPO’s Members in accordance with Fla. Stat. § 641.513(5). United PPO has therefore violated Fla. Stat. § 627.4194(4).

**COUNT VI – Breach of Contract Implied-in-Fact**  
**(against United)**

213. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

214. In addition, and/or in the alternative, at all times material, the Physicians and United have not had a written contract between them governing the rates at which United must reimburse the Physicians for their emergency services.

215. At all times material, the Physicians have not been a participating provider in United's provider network; rather, the Physicians have been out-of-network providers at all times material.

216. United knew that Plaintiffs would provide emergency services to United's Members at all medical facilities at which Plaintiffs' professionals are staffed to provide emergency care and would provide such care to United's Members without seeking or obtaining prior authorization, as prior authorization is not required in connection with the provision of emergency services.

217. The Physicians have rendered emergency services to United's Members.

218. At all times, United was aware that the Physicians were entitled and expected to be paid the fair value of the emergency services they rendered to United's Members.

219. The Physicians understood that United intended to reimburse the Physicians the fair value of the emergency services the Physicians rendered to United's Members in accordance with applicable law.

220. United has acknowledged its responsibility for payment of the Physicians' emergency services rendered to United's Members by regularly and consistently paying the Physicians for such services, albeit at rates lower than what the Physicians are owed under applicable law.

221. United has further acknowledged its responsibility for payment of the Claims at issue in this action, as all such Claims have been processed and adjudicated by United and determined by United to be covered services.



222. With respect to each of the Claims at issue in this action, the Physicians and United have established a contract implied-in-fact pursuant to which United must reimburse the Physicians no less than the fair value of the services provided in compliance with applicable law.

223. United has breached its implied-in-fact contract with the Physicians by reimbursing the Physicians for the Claims at issue at less than the fair value of the services provided.

224. United's breach of its implied-in-fact contract with the Physicians has caused the Physicians damage in an amount to be determined at trial equal to the difference between the fair value of the services provided by the Physicians and the amounts paid by United to the Physicians for the emergency services the Physicians' professionals have rendered to United's Members.

**COUNT VII – Quantum Meruit**  
**(against United)**

225. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

226. In addition, and/or in the alternative, at all times material, the Physicians have conferred a direct benefit upon United by providing valuable emergency services to United's Members. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from the Physicians' provision of emergency services to United's Members because it is through the Physicians' provision of those services that United fulfills its obligations to its Members.

227. There is no dispute that the emergency services at issue that the Physicians provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid the Physicians for them, except at an amount less than the fair value of the services. When the Physicians provide covered emergency services to United's

Members, United receives the benefit of having its contractual obligations to its Members discharged.

228. United has knowledge of the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United received, processed, and adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

229. United has voluntarily accepted and retained the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

230. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by the Physicians, knowing that the Physicians expected and expect to be paid the fair value for their services. However, United has failed to reimburse the Physicians the fair value of the services the Physicians have rendered to United's Members at all times material.

231. Under the present circumstances, it would be inequitable for United to fail to reimburse the Physicians the fair value of the emergency services they rendered to United's Members, while retaining the benefits the Physicians conferred upon United.

232. United is therefore liable in *quantum meruit* to the Physicians for failing to reimburse the Physicians the fair value of the services the Physicians rendered to United's Members with respect to each of the Claims. United owes as damages the difference between the fair value of the services the Physicians rendered to United's Members and the amounts United paid for those services.

**COUNT VIII – Unjust Enrichment**  
**(against United)**

233. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

234. In addition, and/or in the alternative, at all times material, the Physicians have conferred a direct benefit upon United by providing valuable emergency services to United's Members. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from the Physicians' provision of emergency services to United's Members because it is through the Physicians' provision of those services that United fulfills its obligations to its Members.

235. There is no dispute that the emergency services at issue that the Physicians provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid the Physicians for them, except at an amount less than the fair value of the services. When the Physicians provide covered emergency services to United's Members, United receives the benefit of having its contractual obligations to its Members discharged.

236. United has knowledge of the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United received, processed, and adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

237. United has voluntarily accepted and retained the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

238. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by the Physicians, knowing that the Physicians expected and expect to be paid the fair value for their services in accordance with Florida law. However, United has failed to reimburse the Physicians the fair value of the services the Physicians have rendered to United's Members at all times material.

239. Under the present circumstances, it would be inequitable for United to fail to reimburse the Physicians the fair value of the emergency services they rendered to United's Members, while retaining the benefits the Physicians conferred upon United.

240. United has therefore been unjustly enriched by failing to reimburse the Physicians the fair value of the services the Physicians rendered to United's Members. United owes as damages the difference between the fair value of the services the Physicians rendered to United's Members and the amounts United paid for those services.

**COUNT IX – Declaratory Judgment**  
**(against United)**

241. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

242. At all times material, the Physicians have been out-of-network providers when they rendered emergency services to United's Members.

243. At all times material, United has reimbursed the Physicians for the emergency services they have rendered to United's Members at substantially less than the Physicians' charges and the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United's Members. Accordingly, United has failed to reimburse the Physicians for the emergency services the Physicians rendered to United's Members

in accordance with Sections 641.513(5) and 627.64194(4), Florida Statutes. United has therefore violated Sections 641.513(5) and 627.64194(4), Florida Statutes.

244. United continues to reimburse the Physicians for emergency services rendered to United's Members at substantially less than the Physicians' charges and the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United's Members. United has indicated that it intends to continue to reimburse the Physicians for emergency services in such an unlawful manner.

245. United has reimbursed the Physicians for the emergency services it has rendered to United's Members at substantially less than the fair value of the Physicians' services.

246. United continues to reimburse the Physicians for the emergency services they render to United's Members at substantially less than the fair value of the Physicians' services.

247. The Physicians and United intend for the Physicians to continue to provide emergency services to United's Members as out-of-network providers.

248. Based on the foregoing allegations, real and substantial justiciable controversies exist between United and the Physicians concerning whether the rates at which United reimburses the Physicians for emergency services rendered to United's Members violate Sections 641.513(5), and 627.64194(4), Florida Statutes.

249. Based on the foregoing allegations, real and substantial justiciable controversies exist between United and the Physicians concerning the rates of reimbursement to which the Physicians are entitled as out-of-network providers of emergency services to United's Members under the Florida common law doctrines of breach of implied-in-fact contract, *quantum meruit* and unjust enrichment.

250. These are actual, definite, concrete and substantial controversies that require an immediate determination of the Physicians' rights of reimbursement and whether the rates of reimbursement that United has paid to the Physicians comply with Florida law.

251. Declaratory relief is appropriate here because such judgment will serve a useful purpose in clarifying and settling the rates of reimbursement to which the Physicians are entitled from United for the emergency services the Physicians render to United's Members for so long as the Physicians remain out-of-network providers.

252. There is a bona fide, actual, present practical need for a declaration. Declaratory relief will terminate and afford relief from uncertainty, insecurity, and controversy concerning the rates at which United must reimburse the Physicians for the emergency services the Physicians continue to render to United's Members as an out-of-network provider.

253. All antagonistic and adverse interests relating to the declaration sought herein are parties to this action.

254. The relief sought is not merely to seek legal advice of the Court nor do the Physicians seek answers to questions propounded from mere curiosity.

255. The Physicians are consequently entitled to a declaration of their rights pursuant to Section 86.021, Florida Statutes.

### **JURY DEMAND**

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, the Physicians hereby demand a trial by jury of any issue trial of right by a jury.

### **PRAYER FOR RELIEF**

WHEREFORE, the Physicians pray that this Court:

- (i) enter judgments against Defendants and in favor of the Physicians pursuant to the Counts I and II, in an amount constituting treble damages resulting from the

United's underpayments to the Physicians of the emergency services provided to Defendants' members and reasonable attorneys' fees incurred in bringing this action;

- (ii) enter judgments against MultiPlan and in favor of the Physicians pursuant to the Counts III, in an amount equal to the amounts the Physicians' Claims were underpaid and reasonable attorneys' fees incurred in bringing this action;
- (iii) enter judgment against United and in the Physicians' favor, awarding the Physicians compensatory damages for the emergency services the Physicians have rendered to United's Members through the date of judgment;
- (iv) award the Physicians prejudgment and postjudgment interest on the amounts overdue on the underpaid claims;
- (v) award the Physicians their costs;
- (vi) enter an order declaring the rate(s) at which United must reimburse the Physicians for the emergency services the Physicians render to United's Members as an out-of-network provider;
- (vii) issue a mandatory injunction compelling United to reimburse the Physicians no less than the reimbursement rates to which the Court declares the Physicians are entitled from United for the emergency services the Physicians render to United's Members as out-of-network providers; and
- (viii) grant the Physicians any and all further relief as more specifically sought in all preceding paragraphs and as the Court deems just and appropriate under the circumstances.

Respectfully submitted:

/s/ Justin C. Fineberg

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*Counsel for Plaintiffs*



**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on June 9, 2020, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record via transmission of Notices of Electronic Filing generated by CM/ECF.

/s/ Justin C. Fineberg

Justin C. Fineberg, Esq.

# Exhibit 28

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**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF ARIZONA**

Emergency Group of Arizona  
Professional Corp, an Arizona  
Professional Corporation; Emergency  
Physicians Southwest, P.C., an Arizona  
Professional Corporation; Chase Dennis  
Emergency Medical Group, Inc., a  
California Corporation,

Plaintiffs,

vs.

UnitedHealth Group, Inc., a Delaware  
corporation, United Healthcare, Inc., a  
Delaware Corporation; UnitedHealthcare  
of Arizona, Inc., an Arizona Corporation;  
United Health Care Services Inc., a  
Minnesota Corporation; UMR, Inc., a  
Delaware Corporation; UnitedHealthcare  
Integrated Services, Inc., an Arizona  
Corporation; UnitedHealthcare Specialty  
Benefits, LLC, a Maine Limited Liability  
Company; John Does 1-10; Roe Entities  
11-20,

Defendants.

Case No.: 2:19-cv-04687-JJT

**FIRST AMENDED COMPLAINT**

**Jury Trial Demanded**

1 Plaintiffs Emergency Group of Arizona Professional Corp; Emergency Physicians  
2 Southwest, P.C.; and Chase Dennis Emergency Medical Group, Inc. (collectively, the  
3 “Providers”), for their First Amended Complaint against defendants UnitedHealth Group,  
4 Inc. (“UHG”); United Healthcare, Inc. (“UHI”); UnitedHealthcare of Arizona, Inc.  
5 (“UHC Arizona”); United Health Care Services Inc. (“UHC Services”); UMR, Inc.  
6 (“UMR”); UnitedHealthcare Integrated Services, Inc. (“UHC Integrated Services”);  
7 UnitedHealthcare Specialty Benefits, LLC (“UHC Specialty Benefits”) (collectively  
8 “Defendants”) assert as follows:<sup>1</sup>

### 9 NATURE OF THIS ACTION

10 1. Providers are professional emergency medicine service groups that staff  
11 emergency departments at hospitals located throughout Arizona. Providers Treat Patients  
12 24 hours per day, 7 days a week. In fact, Providers are obligated pursuant to Arizona and  
13 Federal law to examine and provide stabilizing care to any individual with an emergency  
14 medical condition without regard to the individual’s ability to pay or availability of  
15 insurance coverage. This action arises out of a dispute concerning the rate of payment at  
16 which Defendants reimburse Providers for the emergency medicine services Providers  
17 have already provided, and continue to provide, to Patients covered under the health plans  
18 underwritten, operated, and/or administered by Defendants (the “Health Plans”) (Health  
19 Plan beneficiaries for whom Providers performed covered services shall be referred to as  
20 “Patients”).<sup>1</sup> Collectively Defendants have manipulated, are continuing to manipulate,  
21 and have conspired to manipulate their third parties payment rates to defraud Providers,

22  
23 <sup>1</sup> Providers file this First Amended Complaint to, among other things, address concerns  
24 expressed by Defendants’ counsel during the required meet and confer regarding motions  
25 to dismiss and to assert additional Arizona state law claim. See ECF No. 6; LRCiv  
26 12.1(c). The filing of the First Amended Complaint addresses Defendants’ request for  
27 additional information to better identify the state law claims at issue in this litigation.  
28 Without waiving the position that Defendants’ removal was improper and the Court lacks  
subject matter jurisdiction (see Motion to Remand, ECF No. 8) and the case should be  
stayed until the Court has an opportunity to adjudicate the Motion to Remand, Providers  
file this amended pleading and anticipate producing a list of claims at issue in the litigation  
in conformity with the Court’s July 18, 2019 Order (ECF No. 12).

1 to deny them reasonable payment for their services which the law requires, and to coerce  
2 or extort Providers into contracts that only provide for manipulated rates. Defendants  
3 have reaped millions of dollars from their illegal, coercive, fraudulent conducts and will  
4 reap millions more if their conduct is not stopped.

5 2. Providers do not assert any causes of action with respect to any Patient  
6 whose health insurance was issued under Medicare Part C (Medicare Advantage) or is  
7 provided under the Federal Employee Health Benefits Act (FEHBA). Providers also do  
8 not assert any claims relating to Defendants' managed Medicaid business or with respect  
9 to the right to payment under any ERISA plan. Finally, Providers do not assert claims  
10 that are dependent on the existence of an assignment of benefits ("AOB") from any of  
11 Defendants' Members. There is – and was -- no basis to remove this lawsuit to federal  
12 court under federal question jurisdiction.

### 13 PARTIES

14 3. Plaintiff Emergency Group of Arizona Professional Corp ("Emergency  
15 Group AZ") is a professional emergency medicine services group practice that staffs the  
16 emergency departments at Abrazo Arizona Heart Hospital, Abrazo Arrowhead Campus,  
17 Abrazo Buckeye Emergency Center, Abrazo Peoria Emergency Center, Abrazo  
18 Scottsdale Campus, Abrazo West Campus, and Arizona Central Campus throughout  
19 Maricopa County, Arizona.

20 4. Plaintiff Emergency Physicians Southwest, P.C. ("Emergency Physicians  
21 SW") is a professional emergency medicine services group practice that staffs the  
22 emergency departments at Banner Baywood Medical Center, Banner Mesa Medical  
23 Center, Banner Casa Grande Medical Center, Banner Page Medical Center, and Banner  
24 Payson Regional Medical Center throughout Maricopa, Pinal, Coconino and Gila  
25 Counties, Arizona.

26 5. Plaintiff Chase Dennis Emergency Medical Group, Inc. ("Chase Dennis")  
27 is a professional emergency medicine services group practice that staffed the emergency  
28

1 departments at Carondelet Holy Cross Hospital and Abrazo Maryvale Campus in  
2 Maricopa and Santa Cruz Counties, Arizona.

3 6. Defendant UnitedHealth Group, Inc. (“UHG”) is the largest single health  
4 carrier in the United States and is a Delaware corporation with its principal place of  
5 business in Minnesota. UHG is a publicly-traded holding company that is dependent upon  
6 monies (including dividends and administrative expense reimbursements) from its  
7 subsidiaries and affiliates which include all of the other Defendant entities named herein.

8 7. Defendant United HealthCare, Inc. (“UHC”) is a Delaware corporation with  
9 its principal place of business in Minnesota. UHC is responsible for administering and/or  
10 paying for certain emergency medical services at issue. It is a subsidiary of Defendant  
11 United Healthcare Services, Inc., and provides administrative services to certain health  
12 insurance plans.

13 8. Defendant UnitedHealthcare of Arizona, Inc. (“UHC Arizona”) is an  
14 Arizona corporation and affiliate of UHC. UHC Arizona is responsible for administering  
15 and/or paying for certain emergency medical services at issue in the litigation. UHC  
16 Arizona is a licensed Arizona health care services organization.

17 9. Defendant United HealthCare Services, Inc. (“UHC Services”) is a  
18 Minnesota corporation with its principal place of business in Minnesota and affiliate of  
19 UHC. UHC Services is responsible for administering and/or paying for certain  
20 emergency medical services at issue.

21 10. Defendant UMR, Inc. (“UMR”) is a Delaware corporation with its principal  
22 place of business in Minnesota and affiliate of UHC. UMR is responsible for  
23 administering and/or paying for certain emergency medical services at issue in the  
24 litigation. UMR is a licensed Arizona life and health administrator.

25 11. Defendant UnitedHealthcare Integrated Services, Inc. (“UHC Integrated  
26 Services”) is an Arizona corporation and affiliate of UHC. UHC Integrated Services is  
27 responsible for administering and/or paying for certain emergency medical services at  
28 issue.

12. Defendant UnitedHealthcare Specialty Benefits, LLC (“UHC Specialty Benefits”) is a Maine limited liability company and affiliate of UHC. UHC Specialty Benefits is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

13. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of John Does 1-10 and Roe Entities 11-20 are currently unknown to Providers, who sue those defendants by such fictitious names. Providers will seek leave of this Court to amend this First Amended Complaint to insert the proper names of the defendant Does and Roe Entities when such names and capacities become known.

### JURISDICTION AND VENUE

14. The amount in controversy exceeds the sum of \$300,000, exclusive of interest, attorneys’ fees and costs. This action will have voluminous documentary evidence and a large number of fact witnesses.

15. The Superior Court, Maricopa County, Arizona has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. Providers contest this Court’s subject matter jurisdiction over the matters alleged herein and have moved to remand to the Superior Court, Maricopa County, Arizona. See Motion to Remand (ECF No. 8). Providers do not waive their continued objection to Defendants’ removal based on alleged preemption under the Employers’ Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Maricopa County, Arizona.

### FACTS COMMON TO ALL CAUSES OF ACTION

#### *The Providers Deliver Necessary Emergency Care to Patients*

16. Providers are professional practice groups of emergency medicine physicians and healthcare providers that provide emergency medicine services 24 hours

1 per day, 7 days per week to Patients presenting to the emergency departments at hospitals  
2 and other facilities in Arizona staffed by the Providers. Providers Emergency Group AZ  
3 and Emergency Physicians SW currently provide emergency department services at 12  
4 hospitals located in Maricopa, Pinal, Coconino, Gila, and Santa Cruz Counties, Arizona.  
5 Provider Chase Dennis provided emergency department services at 2 hospitals in Santa  
6 Cruz and Maricopa Counties, Arizona.

7 17. Providers, and the hospitals whose emergency departments they staff, are  
8 obligated by both federal and Arizona law to examine any individual visiting the  
9 emergency department and to provide stabilizing treatment to any such individual with  
10 an emergency medical condition, regardless of the individual's insurance coverage or  
11 ability to pay. See Emergency Medical Treatment and Active Labor Act (EMTALA), 42  
12 U.S.C. § 1395dd; A.R.S. § 20-2803. Providers fulfill this obligation for the hospitals  
13 which they staff. In this role, Providers' physicians provide emergency medicine services  
14 to all individuals, regardless of insurance coverage or ability to pay, including to Patients  
15 with insurance coverage issued, administered and/or underwritten by Defendants.

16 18. Upon information and belief, Defendants operate as health care services  
17 organizations under A.R.S. § 20-1051 *et seq.* and administrators under A.R.S. § 20-485  
18 *et seq.*

19 19. There is no written agreement between Defendants and Providers for the  
20 healthcare claims at issue in this litigation. Providers are therefore designated as "non-  
21 participating" or "out-of-network" providers for all of the claims at issue. An implied-in-  
22 fact agreement exists between Providers and Defendants, however.

23 20. Because federal and state law requires that emergency services be provided  
24 to individuals by Providers without regard to insurance status or ability to pay, the law  
25 protects emergency service providers -- like Providers here -- from predatory conduct by  
26 payors, including the kind of conduct that Defendants have practiced leading to this  
27 dispute. If the law did not do so, emergency service providers would be at the mercy of  
28 such payors. Providers would be forced to accept payment at any rate or no rate at all



dictated by insurers under threat of receiving no payment, and then Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse Providers at a reasonable rate or the usual and customary rate for services they provide.

21. Providers regularly provide emergency services to Defendants' Patients.

22. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

23. The uhc.com website, expressly states:

There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

24. Providers have provided emergency medicine services to Defendants' Patients on an out-of-network basis as follows:

a. Emergency Group AZ: Since February 1, 2013 at the emergency departments at Abrazo Arizona Heart Hospital, Abrazo Arrowhead Campus, Abrazo Buckeye Emergency Center, Abrazo Peoria Emergency Center, Abrazo Scottsdale Campus, Abrazo West Campus, and Arizona Central Campus;

b. Emergency Physicians SW: From April 1, 2019 through the present and ongoing at the emergency departments at Banner Baywood Medical Center, Banner Mesa Medical Center, Banner Casa Grande Medical Center, Banner Page Medical Center, and Banner Payson Regional Medical Center throughout Maricopa, Pinal, Coconino and Gila Counties, Arizona;

1 c. Chase Dennis: Between February 1, 1997 and December 31, 2016,  
2 at the emergency department at Carondelet Holy Cross Hospital; and between August 1,  
3 2006 and December 17, 2017 at the emergency department at Abrazo Maryvale Campus.

4 25. Defendants have generally adjudicated and paid claims with dates of service  
5 through April 30, 2019. As the claims continue to accrue, so do Providers' damages. For  
6 each of the claims for which Providers seek damages, Defendants have already  
7 determined the claim was covered and payable.

8 ***The Relationship Between Plaintiffs and Defendants***

9 26. Defendants provide health insurance to their members (*i.e.*, their insureds).

10 27. In exchange for premiums, fees, and/or other compensation, Defendants  
11 assume responsibility for paying for health care services rendered to members covered by  
12 their health plans.

13 28. In addition, Defendants provide services such as building participating  
14 provider networks and negotiating rates with providers who join their networks.

15 29. Defendants offer a range of health insurance plans. Plans generally fall into  
16 one of two categories.

17 30. "Fully Funded" plans are plans in which Defendants collect premiums  
18 directly from their members (or from third parties on behalf of their members) and pay  
19 claims directly from the pool of funds created by those premiums.

20 31. "Employer Funded" plans are plans in which Defendants provide  
21 administrative services to their employer clients, including processing, analysis, approval,  
22 and payment of health care claims, using the funds of the claimant's employer.

23 32. Defendants provide coverage for emergency medical services under both  
24 types of plans.

25 33. They are contractually and legally responsible for ensuring that their  
26 members can receive such services (a) without obtaining prior approval and (b) without  
27 regard to the "in network" or "out-of-network" status of the emergency services provider.

28 34. Defendants highlight such coverage in marketing their insurance products,  
inducing members to purchase their products and rely upon those representations.

1           35. For example, on the “patient protections” section of the UnitedHealthcare  
2 website, uhc.com, Defendants state:

3           There are no prior authorization requirements for emergency services in a  
4 true emergency, even if the emergency services are provided by an out-of-  
5 network provider. Payment for the emergency service will follow the plan  
6 rules for network emergency coverage. This provision applies to all non-  
7 grandfathered fully insured and self-funded group health plans [Fully  
8 Funded plans], as well as group and individual health insurance issuers  
9 [Employer Funded plans].

10           36. Payors typically demand a lower payment rate from contracted participating  
11 providers.

12           37. In return, they offer participating providers certainty and timeliness of  
13 payment, access to the payor’s formal appeals and dispute resolution processes, and other  
14 benefits.

15           38. For all claims at issue in this lawsuit, Plaintiffs were non-participating  
16 providers, meaning they did not have an express contract with Defendants to accept or be  
17 bound by Defendants’ reimbursement policies or in-network rates.

18           39. Specifically, the reimbursement claims within the scope of this action are  
19 (a) non-participating commercial claims (including for patients covered by Affordable  
20 Care Act Exchange products), (b) that were adjudicated as covered, and allowed as  
21 payable by Defendants, (c) at rates below the billed charges and a reasonable payment for  
22 the services rendered, (d) as measured by the community where they were performed and  
23 by the person who provided them. These claims are collectively referred to herein as the  
24 “Non-Participating Claims.”

25           40. The Non-Participating Claims involve only commercial and Exchange  
26 Products operated, insured, or administered by the insurance company Defendants. They  
27 do not involve Medicare Advantage or Medicaid products.

28           41. Further, the Non-Participating Claims at issue under Counts III, IV, and V  
do not involve coverage determinations under any health plan that may be subject to the

1 federal Employee Retirement Income Security Act of 1974, or claims for benefits based  
2 on assignment of benefits.<sup>2</sup>

3 42. Those counts concern the *rate* of payment to which Plaintiffs are entitled,  
4 not whether a *right* to receive payment exists.

5 43. Defendants bear responsibility for paying for emergency medical care  
6 provided to their members regardless of whether the treating physician is an in-network  
7 or out-of-network provider.

8 44. Defendants understand and expressly acknowledge that their members will  
9 seek emergency treatment from non-participating providers and that Defendants are  
10 obligated to pay for those services.

11 ***The Reasonable Rate for Non-Participating Emergency Services is Well-Established***

12 45. For many years, Defendants have allowed payment at 75-90% of billed  
13 charges for Plaintiffs' emergency services.

14 46. Defendants have done so largely through the use of rental networks, which  
15 establish a reasonable rate for provider services through arms-length negotiations between  
16 the rental network and providers on the one hand, and the rental network and health  
17 insurance companies on the other.

18 47. Rental networks act as "brokers" between non-participating providers and  
19 health insurance companies.

20 48. A rental network will secure a contract with a provider to discount its out-  
21 of-network charges.

22 49. The rental network then contracts with (or "rents" its network to) health  
23 insurance companies to allow the insurer access to the rental network and to the providers'  
24 agreed-upon discounted rates.

25  
26  
27  
28 <sup>2</sup> Plaintiffs understand, in any event, that Defendants do not require or rely upon  
assignments from their members in order to pay claims for services provided by Plaintiffs  
to their members.

1           50. As such, rental networks' negotiated rates act as a proxy for a reasonable  
2 rate of reimbursement for out-of-network emergency services, both in the industry as a  
3 whole and for particular payors.

4           51. For many years, Plaintiffs' contracts with a range of rental networks,  
5 including MultiPlan, have contemplated a modest discount from Plaintiffs' billed charges  
6 for claims adjudicated through the rental network agreement.

7           52. In practice, nearly all of Plaintiffs' non-participating provider claims  
8 submitted under Employer Funded plans from 2008 to 2018 were paid at between 75-  
9 90% of billed charges, including the Non-Participating Claims submitted to Defendants.

10           53. This longstanding history establishes that a reasonable reimbursement rate  
11 for Plaintiffs' Non-Participating Claims for emergency services is 75-90% of Plaintiffs'  
12 billed charge.

13           54. Beginning in January 2019, Defendants have slashed their reimbursement  
14 rate for Non-Participating Claims to less than half the average reasonable reimbursement  
15 rate.

16           55. Defendants' drastic payment cuts are entirely inconsistent with the  
17 established rate and history between the parties.

18                           ***Defendants Paid Providers Unreasonable Rates***

19           56. Defendants arbitrarily began manipulating the rate of payment for claims  
20 submitted by Providers. Defendants drastically reduced the rates at which they paid  
21 Providers for emergency services for some claims, but not others. Instead of paying a  
22 usual and customary rate of the charges billed by Providers, Defendants paid some of the  
23 claims for emergency services rendered by Providers at far below the usual and customary  
24 rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with  
25 the same Current Procedural Terminology (CPT) Code, as maintained by American  
26 Medical Association) submitted by Providers at higher rates and in some instances at  
27 100% of the billed charge.  
28

1 a. For example, on April 28, 2019, Defendants' Member #1,<sup>3</sup> presented  
2 to the emergency department at Abrazo Arizona Heart Hospital and was treated by  
3 Provider Emergency Group AZ. The professional services were billed with CPT Code  
4 99285 (the presenting problem(s) are of high severity and pose an immediate significant  
5 threat to life or physiologic function) in the amount \$1,809.00; Defendants paid \$435.20,  
6 which is just 24% of the charges billed. By contrast, on April 26, 2019, Defendants'  
7 member #2 presented to the emergency department at Abrazo Scottsdale Campus and was  
8 treated by Provider Emergency Group AZ. The professional services were billed with  
9 CPT Code 99285 in the amount \$1,809.00; Defendants paid \$1,809.00, 100% of the  
10 charges billed.

11 b. By way of further example, between February 3 and April 26, 2019,  
12 Defendants' Members #3, #4, #5 and #6 all presented to emergency departments staffed  
13 by Provider Emergency Group AZ. In each instance the professional services were billed  
14 with CPT Code 99285 and Defendants paid 100% of the billed charges. By contrast, on  
15 February 3 and 4, 2019, Defendants' Members #7, #8 and #9 all presented to emergency  
16 departments staffed by Provider Emergency Group AZ. In each instance, the professional  
17 services were billed with CPT Code 99285 and Defendants only paid 40% of the billed  
18 charges.

19 57. Each Provider's claims are identified more specifically as follows:

20 c. Emergency Group AZ:  
21 i. Dates of service: January 1, 2016 to April 30, 2019 (and  
22 ongoing).  
23 ii. Litigation claims: approximately 6,986 claims.  
24 iii. Providers seek payment for all claims paid at less than 75%  
25 of billed charges.

26 d. Emergency Physicians SW:  
27 i. Dates of service: April 1 to April 30, 2019 (and ongoing).

28 <sup>3</sup> To protect identity and personal health information, Providers have assigned numbers to each individual identified. Upon request, Providers will provide Defendants with additional identifying information for the examples provided.

ii. Litigation claims: approximately 729 claims.  
iii. Providers seek payment for all claims paid at less than 75% of billed charges.

e. Chase Dennis:  
i. Dates of service: January 6, 2016 to December 14, 2017.  
ii. Litigation claims: approximately 155 claims.  
iii. Providers seek payment for all claims paid at less than 75% of billed charges.<sup>4</sup>

f. Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants plan who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledges that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

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<sup>4</sup> None of these examples include any claims that were denied in whole by any of the Defendants, or any individual evaluation and management (E/M) code that was denied as part of a claim for which Defendants otherwise deemed eligible for payment.



62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse Providers at the usual and customary rate for emergency services Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from Providers' physicians: treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. From January 2016 to the present, Providers provided treatment for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of \$300,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

65. Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to Providers. Defendants implemented this program to coerce, influence and leverage business discussions with Providers to become participating providers at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

68. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.



69. Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

***Defendants' Prior Manipulation of Reimbursement Rates***

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

71. In 2009, defendant UnitedHealth Group, Inc., was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a \$50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants United HealthGroup, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid \$350 million to settle class action claims alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

1           76. Since its inception, FAIR Health’s benchmark databases have been used by  
2 state government agencies, medical societies, and other organizations to set  
3 reimbursement for non-participating providers.

4           77. For example, the State of Connecticut uses FAIR Health’s database to  
5 determine reimbursement for non-participating providers’ emergency services under the  
6 state’s consumer protection law.

7           78. Defendants tout the use of FAIR Health and its benchmark databases to  
8 determine non-participating, out-of-network payment amounts on its website.

9           79. As stated on UnitedHealthCare’s website  
10 (<https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits>) for  
11 non-participating provider claims, the relevant United Health Group affiliate will “in  
12 many cases” pay the lower of a provider’s actual billed charge or “the reasonable and  
13 customary amount,” “the usual customary and reasonable amount,” “the prevailing rate,”  
14 or other similar terms that base payment on what health care providers in the geographic  
15 area are charging.

16           80. While Defendants give the appearance of remitting reimbursement to non-  
17 participating providers that meet usual and customary rates and/or the reasonable value  
18 of services based on geography that is measured from independent benchmark services  
19 such as the FAIR Health database, Defendants have found other ways to manipulate the  
20 reimbursement rate downward from a usual and customary or reasonable rate in order to  
21 maximize profits at the expense of Providers.

22           81. For example, beginning in or around 2009, Defendants imposed significant  
23 cuts to Providers’ reimbursement rate for out-of-network claims under Defendants’ fully  
24 funded plans, without rationale or justification.

25           82. Defendants pay claims under fully funded plans out of their own pool of  
26 funds, so every dollar that is not paid to Providers is a dollar retained by Defendants for  
27 their own use.  
28

83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payment to Providers at rates less than 20% of billed charges.

84. For example, for Member #10 who, upon information and belief, is a member of a fully funded plan treated by Provider Emergency Group AZ on April 22, 2019, Providers billed Defendants \$1,212.00 for CPT Code 99284, the code used for a moderately severe problem, and Defendants allowed just 19.2% of billed charges, or \$233.22, a rate significantly below reasonable rates.

85. As another example, on April 23, 2019, Provider Emergency Group AZ treated Member #11 who, upon information and belief, is a member of a fully funded plan, and billed Defendants \$1,212.00 for CPT Code 99284. Defendants allowed 20% of billed charges, or \$246.34.

86. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid Providers a reasonable rate for those services since 2009.

87. In so doing, Defendants have illegally retained those funds.

#### ***Defendants' Current Schemes***

88. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to Providers.

89. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

90. As part of these negotiations, Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

1           91.     Around December 2017, Mr. Rosenthal told Providers' representatives that  
2 Defendants intended to implement a new benchmark pricing program specifically for  
3 their employer funded plans to decrease the rate at which such claims were to be paid.

4           92.     Defendants then proposed a contractual rate for their employer funded plans  
5 that was roughly half the average reasonable rate at which Defendants have historically  
6 reimbursed providers – a drastic and unjustified discount from what Defendants have been  
7 paying Providers for years on their non-participating claims in these plans, and an amount  
8 materially less than what Defendants were paying other contracted providers in the same  
9 market.

10          93.     Defendants' proposed rate was neither reasonable nor fair.

11          94.     In May 2018, Mr. Rosenthal escalated his threats, making clear during a  
12 meeting that, if Providers did not agree to contract for the drastically reduced rates,  
13 Defendants would implement benchmark pricing that would reduce Plaintiffs' non-  
14 participating reimbursement by 33%.

15          95.     Dan Schumacher, the President and Chief Operating Officer of  
16 UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant  
17 UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut Providers' non-  
18 participating reimbursement by 50%.

19          96.     Asked why Defendants were forcing such dramatic cuts on Providers'  
20 reimbursement, Mr. Schumacher said simply "because we can."

21          97.     Defendants made good on their threats and knowingly engaged in a  
22 fraudulent scheme to slash reimbursement rates paid to Providers for non-participating  
23 claims submitted under their employer funded plans to levels at, or even below, what they  
24 had threatened in 2018.

25          98.     Defendants falsely claim that their new rates comply with the law because  
26 they contracted with a purportedly objective and transparent third party, Data iSight, to  
27 process Providers' claims for employer funded plans and to determine reasonable  
28 reimbursement rates.

1            99. Data iSight is the trademark of an analytics service used by health plans to  
2 set payment for claims for services provided to Defendants' Members by non-  
3 participating providers. Data iSight is owned by National Care Network, LLC, a  
4 Delaware limited liability company with its principal place of business in Irving, Texas.  
5 Data iSight and National Care Network, LLC will be collectively referred to as "Data  
6 iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York  
7 corporation with its principal place of business in New York, NY. MultiPlan acts as a  
8 Rental Network "broker" and, in this capacity, has contracted since 2011 with Providers  
9 Emergency Physicians SW and Chase Dennis and since 2013 with Provider Emergency  
10 Group AZ to secure reasonable rates from payors for Providers' non-participating  
11 emergency services. Providers have no contract with Data iSight, and the non-  
12 participating claims identified in this action are not adjudicated pursuant to the MultiPlan  
13 agreement.

14            100. Since January 2019, Defendants have engaged in a scheme and conspired  
15 with Data iSight to impose arbitrary and unreasonable payment rates on Providers under  
16 the guise of utilizing an independent, objective database purportedly created by Data  
17 iSight to dictate the rates imposed by Defendants.

18            101. Defendants also continued to advance this scheme on the negotiation front.

19            102. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants  
20 planned to cut Providers' rates over three years to just 42% of the average and reasonable  
21 rate of reimbursement that Providers had received in 2018 if Providers did not formally  
22 contract with them at the rate dictated by Defendants.

23            103. Mr. Schumacher additionally advised that leadership across the Defendant  
24 entities were aware and supportive of the drastic cuts and provided no objective basis for  
25 them.

26            104. The next day, Angie Nierman, a Vice President of Networks at  
27 UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated  
28 cuts.

1           105. In addition to denying Providers what is owed to them for the Non-  
2 Participating Claims, Defendants' scheme is an attempt to use their market power to reset  
3 the rate of reimbursement to unreasonably low levels.

4           ***RICO Defendants' Fraudulent Schemes to Deprive Providers of Reasonable***  
5           ***Reimbursement Violates Arizona's Civil Racketeering Statute***

6           106. Each Defendant, UnitedHealth Group, Inc., United Healthcare, Inc.,  
7 UnitedHealthcare of Arizona, Inc., United Health Care Services Inc., UMR, Inc.;  
8 UnitedHealthcare Integrated Services, Inc. and UnitedHealthcare Specialty Benefits, LLC  
9 (collectively, the "RICO Defendants") violated AZ RICO (A.R.S. § 13-2301 *et seq.*), and  
10 in particular, A.R.S. § 13-2314.04 in connection with a scheme or artifice to defraud  
11 Providers through a pattern of unlawful activity in which the RICO Defendants devised,  
12 conducted, and participated in with unnamed third parties, including, but not limited to,  
13 Data iSight, in order to obtain benefits by means of false or fraudulent pretenses,  
14 representations, promises and material omissions.

15           107. The Enterprise, as defined in A.R.S. § 13-2301(D)(2), consists of the RICO  
16 Defendants, non-parties Data iSight and other entities that develop software used in  
17 reimbursement determinations used by the RICO Defendants (the "Enterprise"). The  
18 participants of the Enterprise are associated, upon information and belief, by virtue of  
19 contractual agreement(s) and/or other arrangement(s) wherein they have agreed to  
20 undertake a common goal of reducing payments to Providers for the benefit of the  
21 Enterprise. The Enterprise participants communicate routinely through telephonic and  
22 electronic means as they unilaterally impose reimbursement rates based on their  
23 manipulated "data" but which is nothing more than a transparent attempt to impose  
24 artificially reduced reimbursement rates that the RICO Defendants threatened during  
25 business-to-business negotiations.

26           108. The RICO Defendants illegally conduct the affairs of the Enterprise, and/or  
27 control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.  
28

1           109. As part of this scheme, the RICO Defendants prepared to, and did  
2 knowingly and unlawfully, reduce Providers' reimbursement rates for the non-  
3 participating claims to amounts significantly below the reasonable rate for services  
4 rendered to RICO Defendants' Members, to the detriment of Providers and to the benefit  
5 and financial gain of RICO Defendants and Data iSight.

6           110. To carry out the scheme and in furtherance of the conspiracy, RICO  
7 Defendants and Data iSight engaged in conduct that violated Arizona laws, including,  
8 *inter alia*, A.R.S. §§ 13-2310, 13-2312.

9           111. Since January 2019, the Enterprise worked together to manipulate and  
10 artificially lower non-participating provider reimbursement data that coincides and  
11 matches the earlier threats made by United Health Group in an effort to avoid paying  
12 Providers for the usual and customary fee or rate and/or for the reasonable value of the  
13 services provided to Defendants' Members for emergency medicine services. The  
14 unilateral reduction in reimbursement rates is not founded on actual statistically sound  
15 data, and is not in line with reimbursement rates that can be found through sites such as  
16 the FAIR Health database, a recognized source for such reimbursement rates. Each time  
17 the RICO Defendants direct payment using manipulated reimbursement rates and issue  
18 Providers a remittance, the RICO Defendants further their scheme or artifice to defraud  
19 Providers because the RICO Defendants retain the difference between the amount paid  
20 based on the artificially reduced reimbursement rate and the amount paid that should be  
21 paid based on the usual and customary fee or rate and/or the reasonable value of services  
22 provided, to the detriment of the Providers who have already performed the services being  
23 billed. Further, Providers' representatives have contacted Data iSight and have been  
24 informed that acceptable reimbursement rates are actually influenced and/or determined  
25 by Defendants, not Data iSight.

26           112. As a result of the scheme, RICO Defendants have injured Providers in their  
27 business or property by a pattern of unlawful activity in violation of A.R.S. § 13-2314.04.  
28



***RICO Defendants and Data iSight's Activities  
Constitute a Pattern of Unlawful Activity***

113. RICO Defendants and Data iSight committed, and continue to commit, related predicate acts of unlawful activity, pursuant to a scheme or artifice to defraud, knowingly obtain benefits by means of false or fraudulent pretenses, representations, promises or material omissions and illegally controlled an enterprise through unlawful acts, such that they have engaged in a “pattern of racketeering activity” under A.R.S. § 13-2310 and § 13-2312 and pose a continued threat of unlawful activity, as described below.

114. RICO Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to Providers for the emergency services that Providers provided to Defendants’ Members, to the financial gain of the RICO Defendants and Data iSight.

115. The pattern of unlawful activity has happened on more than two occasions that have happened within five years of each other. In fact, the RICO Defendants have processed and submitted a substantial number of artificially reduced payments to Providers since January 2019.

116. As a direct and proximate result of those activities, Providers have suffered in excess of one million dollars in discrete and direct financial loss that stem from the RICO Defendants’ knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

***The Enterprise and Scheme***

117. The Enterprise is comprised of RICO Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by RICO Defendants.

118. RICO Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to Providers through acts of the Enterprise.



1 119. The RICO Defendants and Data iSight conceal their scheme by hiding  
2 behind written agreements and/or other arrangements, and false statements.

3 120. Since at least January 1, 2019, the RICO Defendants, by virtue of their  
4 engagement and use of Data iSight, have falsely claimed to provide transparent, objective,  
5 and geographically-adjusted determinations of reimbursement rates.

6 121. In reality, Data iSight is used as a cover for RICO Defendants to justify  
7 paying reimbursement to Providers at rates that are far less than the reasonable payment  
8 rate that Providers have historically received and are entitled to under the law. The  
9 reimbursement rates purportedly collected and employed by Data iSight are nothing more  
10 than an instrumentality for the RICO Defendants' unilateral decision to stop paying  
11 Providers the usual and customary fee and/or the reasonable value of the services  
12 provided.

13 122. This scheme is concealed through the use of false statements on Data  
14 iSight's website and in RICO Defendants' and Data iSight's communications with  
15 providers, including Providers' representatives.

16 123. The Enterprise's scheme, as described below, was, and continues to be,  
17 accomplished through written agreements, association, and sharing of information  
18 between RICO Defendants and Data iSight.

19 ***The Enterprise's False Statements: Transparency***

20 124. By the end of June 2019, just over half of non-participating claims  
21 submitted to RICO Defendants were being processed for payment by Data iSight.

22 125. The Data iSight website claims to offer "Transparency for You, the  
23 Provider," and that the "website makes the process for determining appropriate payment  
24 transparent to [providers]. . . so all parties involved in the billing and payment process  
25 have a clear understanding of how the reduction was calculated."

26 126. Contrary to these claims, however, the Enterprise, through Data iSight, uses  
27 layers of obfuscation to hide and avoid providing the basis or method it uses to derive its  
28 purportedly "appropriate" rates.

1           127. This concealment was designed by the Enterprise to, and does, prevent  
2 Providers from receiving a reasonable payment for the services they provide.

3           128. For claims whose reimbursement is determined by Data iSight, non-  
4 participating providers receive a Provider Remittance Advice form (“Remittance”) from  
5 Defendants with “IS” or “IJ” in the “Remark/Notes” column.

6           129. Over the past six months, an ever-increasing number of non-participating  
7 claims have been processed by Data iSight with drastically reduced payment amounts.

8           130. Yet RICO Defendants and Data iSight do not state, on the face of the  
9 Remittance, or anywhere else, any reason for the dramatic cut.

10           131. Instead, the Remittances contain a note to call a toll-free number if there are  
11 questions about the claim.

12           132. In July 2019, a representative of Provider Emergency Group AZ contacted  
13 Data iSight via that number to discuss a claim with CPT Code 99284 (emergency  
14 department visit, problem of high severity) which had been billed at \$1,190.00, but for  
15 which Data iSight had allowed and paid \$295.28, just 24.8% of billed charges.

16           133. After Provider’s representative spoke with Data iSight’s intake  
17 representative, a Data iSight representative, Michele Ware (“Ware”), called back and  
18 claimed the billed charges were paid based on a percentage of the Medicare fee schedule.  
19 Provider’s representative challenged the reasonableness of the \$295.28 payment. After  
20 learning that Provider had not yet billed Defendants’ Member for the difference, Ware  
21 stated “ok – so you’re willing negotiate” and offered to pay 80% of billed charges. In  
22 response, Provider’s representative asked for payment of 85% of billed charges –  
23 \$1,011.50 – to which Ware promptly agreed.

24           134. Immediately thereafter, Ware sent a written agreement for Provider’s  
25 representative to review and sign, confirming payment of \$1,011.50 as payment in full  
26 and an agreement not to balance bill Defendants Services’ Member or Member’s Family.

27           135. Providers’ representatives have experienced this same trend across the  
28 country with Data iSight. In one instance, when asked to provide the basis for the

1 dramatic cut in payment for the claims, a Data iSight representative by the name of Phina  
2 (Last Name Unknown) (“LNU”), did not and could not explain how the amount was  
3 derived or how it was determined that a cut was appropriate at all. The representative  
4 could only say that the payments on the claims represented a certain percentage of the  
5 Medicare fee schedule; she could not explain how Data iSight had arrived at that payment  
6 for either of the two claims, or why it allowed a different amount for each claim.

7 136. Instead, the representative simply stated that the rates were developed by  
8 Data iSight and Defendants. When Providers continued to pursue the issue and spoke  
9 with a Data iSight supervisor, James LNU, to inquire as to the basis for these  
10 determinations, James LNU responded that “it is just an amount that is recommended and  
11 sent over to United [HealthCare].” When James LNU was expressly challenged on Data  
12 iSight’s false claim that it is transparent with providers, he responded with silence.

13 137. Further attempts to understand Data iSight and obtain information about the  
14 basis for its reimbursement rate-setting from Data iSight executives have also been futile.

15 138. Data iSight and the RICO Defendants know that the rates that Data iSight  
16 have allowed for Providers’ claims in 2019 are unreasonable and are not, in fact, based  
17 on objective, reliable data designed to arrive at a reasonable reimbursement rate.

18 139. Defendants know this because when a provider challenges the payment,  
19 Data iSight and RICO Defendants are authorized to revise the allowed amount back up to  
20 a reasonable rate, but only if the Provider persists long enough in the process.

21 140. This process to contest the unreasonable payment takes weeks to conclude  
22 for the Provider and is impracticable to follow for every claim – a fact that RICO  
23 Defendants and Data iSight understand.

24 141. For example, as evidence of this fraudulent practice Providers’  
25 representatives contested the allowed amounts on the claims discussed above.

26 142. Eventually, Data iSight’s “Quality Control” team, offered to allow payment  
27 of both claims at 85% of their respective billed charges.  
28

1 143. Absent providers taking the time to chase every claim, Data iSight and  
2 RICO Defendants are able to get away with paying a rate that they know is not based on  
3 objective data and is far below the reasonable one.

4 144. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable  
5 rates unless and until Providers challenge its determinations continually harms Providers,  
6 in that, even if Providers eventually receive reasonable reimbursement upon contesting  
7 the rate, this scheme burdens Providers with excessive administrative time and expense  
8 and deprives Providers of their right to prompt payment.

9 ***The Enterprise's False Statements: Representations that Payment Rates Are***  
10 ***"Defensible and Market Tested"***

11 145. The Enterprise's claim to "transparency" is not its only fraudulent  
12 representation.

13 146. The Enterprise, through Data iSight, also falsely represents, on Data  
14 iSight's website, to set reimbursement rates in a "defensible, market tested" way.

15 147. Claims processed by Data iSight contain the following note:

16 MEMBER: THIS SERVICE WAS RENDERED BY AN  
17 OUT-OF-NETWORK PROVIDER AND PROCESSED  
18 USING YOUR NETWORK BENEFITS. IF YOU'RE  
19 ASKED TO PAY MORE THAN THE DEDUCTIBLE,  
20 COPAY AND COINSURANCE AMOUNTS SHOWN,  
21 PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR  
22 VISIT DATAISIGHT.COM. THEY WILL WORK WITH  
23 THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS**  
24 **SERVICE HAS BEEN REIMBURSED USING DATA**  
25 **ISIGHT WHICH UTILIZES COST DATA IF**  
26 **AVAILABLE (FACILITIES) OR PAID DATA**  
27 **(PROFESSIONALS).** PLEASE DO NOT BILL THE  
28 PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE,  
COPAY AND COINSURANCE APPLIED TO THIS  
SERVICE. IF YOU HAVE QUESTIONS ABOUT THE  
REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

148. This note is intended to, and does, mislead Providers to believe that the reimbursement calculations are tied to external, objective data.

149. Further, in its provider portal, Data iSight describes its “methodology” for reimbursement determinations as “calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor.”

150. Data iSight’s parent company, MultiPlan, similarly describes Data iSight’s process as using “cost- and reimbursement-based methodologies” and notes that it has been “[v]alidated by statisticians as effective and fair.”

151. These statements are false.

152. Data iSight’s rates are not data-driven: they match the rate threatened by RICO Defendants in 2018 and are whatever RICO Defendants want, and direct Data iSight, to allow.

153. For example, over three months, Providers submitted claims for three patients who, upon information and belief, are members of employer funded plans under CPT Code 99284, but received reimbursement in very different allowed amounts:

a. Member #12 was treated by Provider Emergency Group of AZ on January 31, 2019. Provider billed RICO Defendants \$579.00 for procedure code 99284, and RICO Defendants allowed \$521.10 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by RICO Defendants to Provider for non-participating provider services.

b. But, for Member #13, who was treated by Provider Emergency Group AZ on January 3, 2019, RICO Defendants, through Data iSight, allowed only \$295.28, which is only 24% of billed charges (\$1,190.00).

c. For Member #14, who was treated by Provider on January 25, 2019, Provider billed \$1,212.00 for the same procedure code and RICO Defendants, through Data iSight, allowed only \$413.39, or 34% of billed charges.

1           154. In another example, Plaintiffs submitted claims under CPT Code 99285 for  
2 patients in, upon information and belief, employer funded plans, again within weeks of  
3 each other, but RICO Defendants reimbursed at dramatically different and decreasing  
4 levels, negating any claim RICO Defendants have that their reimbursement  
5 determinations are tied to a reasonable, defensible, market-tested standard:

6           d. Member #15 was treated by Provider Emergency Group AZ on  
7 January 27, 2019. Provider billed RICO Defendants \$568.00 for CPT Code 99284, and  
8 RICO Defendants, through MultiPlan, allowed \$511.20, which is 90% of Provider's billed  
9 charge.

10           e. Then, for Member #16, who was seen by Provider Emergency Group  
11 AZ on January 1, 2019, the RICO Defendants, through Data iSight, allowed only \$413.39,  
12 which is approximately 34% of Provider's billed charges of \$1,190.00.

13           155. This lock-step reduction, consistent with RICO Defendants' 2018 threats to  
14 drastically reduce rates even further if Providers failed to agree to their proposed  
15 contractual rates, spans a significant number of Providers' claims for payment for services  
16 to RICO Defendants' Members.

17           156. From the above examples, it is clear that Data iSight is not using any  
18 externally-validated methodology to establish a reasonable reimbursement rate, as its rates  
19 are not consistent, defensible, or reasonable.

20           157. Rather, RICO Defendants, in complicity with Data iSight, increasingly  
21 reimburse for Providers at entirely unreasonable rates, in retaliation for Providers'  
22 objections to their reimbursement scheme, and completely contrary to their false  
23 assertions designed to mislead Providers and similar providers into believing that they will  
24 receive payment at reasonable rates.

25           158. This reimbursement is dictated by RICO Defendants, to the financial  
26 detriment of Providers.

***The Enterprise's False Statements: Geographic Adjustment***

159. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

160. Indeed, on its provider portal, Data iSight falsely claims that “[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area.”

161. Data iSight's parent company, MultiPlan, further falsely states on its website that:

For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

162. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with RICO Defendants to cut uniformly out-of-network provider payments across geographic locations.

163. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed RICO Defendants \$779 for procedure code 99284, and RICO Defendants, via Data iSight, allowed \$413.39.

164. Four days later, on January 25, 2019, Provider Emergency Group of AZ treated Member AZ in Arizona and billed RICO Defendants \$1,212.00 for CPT Code 99284 and RICO Defendants, via Data iSight, allowed exactly \$413.39.



1 165. On the same date, Member NH was treated on the other side of the country  
2 in New Hampshire. The provider billed RICO Defendants \$1,047 for procedure 99284,  
3 and RICO Defendants, via Data iSight, again allowed \$413.39.

4 166. On February 8, 2019, Member OK was treated in Oklahoma. The provider  
5 billed RICO Defendants \$990 for procedure code 99284, and RICO Defendants, via Data  
6 iSight, allowed \$413.39.

7 167. Two days later, Members KS and NM were treated in Kansas and New  
8 Mexico, respectively. The providers billed RICO Defendants \$778.00 and \$895.00,  
9 respectively, for procedure code 99284, but for both of these claims, RICO Defendants,  
10 via Data iSight, allowed exactly \$413.39.

11 168. One month later, Member CA was treated in California. The provider billed  
12 RICO Defendants \$937.00 for procedure code 99284. RICO Defendants, via Data iSight,  
13 yet again allowed exactly \$413.39.

14 169. Two months later, on May 20, 2019, a provider treated Member PA in  
15 Pennsylvania and billed RICO Defendants \$1,094 for procedure code 99284, and RICO  
16 Defendants, via Data iSight, allowed exactly \$413.39.

| Patient | Location      | Date of Service | Billed Amount | CPT Code | Allowed Amount |
|---------|---------------|-----------------|---------------|----------|----------------|
| WY      | Wyoming       | 1/21/19         | \$779         | 99284    | \$413.39       |
| AZ      | Arizona       | 1/25/19         | \$1,212       | 99284    | \$413.39       |
| NH      | New Hampshire | 1/25/19         | \$1047        | 99284    | \$413.39       |
| OK      | Oklahoma      | 2/8/19          | \$990         | 99284    | \$413.39       |
| KS      | Kansas        | 2/10/19         | \$778         | 99284    | \$413.39       |
| NM      | New Mexico    | 2/10/19         | \$895         | 99284    | \$413.39       |
| CA      | California    | 3/25/19         | \$937         | 99284    | \$413.39       |
| PA      | Pennsylvania  | 5/20/19         | \$1,094       | 99284    | \$413.39       |

25 170. RICO Defendants falsely claim on their website to “frequently use” the 80th  
26 percentile of the FAIR Health Benchmark databases “to calculate how much to pay for  
27 out-of-network services.”  
28



171. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed \$413.39:

| Location      | CPT Code | 80 <sup>th</sup> Percentile of Fair Health Benchmark |
|---------------|----------|------------------------------------------------------|
| Wyoming       | 99284    | \$1,105                                              |
| New Hampshire | 99284    | \$753                                                |
| Oklahoma      | 99284    | \$1,076                                              |
| Kansas        | 99284    | \$997                                                |
| New Mexico    | 99284    | \$1,353                                              |
| California    | 99284    | \$795                                                |
| Pennsylvania  | 99284    | \$859                                                |
| Arizona       | 99284    | \$1,265                                              |

*The Enterprise's Predicate Acts*

172. To perpetuate the scheme and conceal it from Providers, in or around 2018, RICO Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

173. Under those contracts, Data iSight would handle claims determinations for services rendered to RICO Defendants' Members under pre-agreed thresholds set by RICO Defendants.

174. By no later than 2019, RICO Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including Providers, in furtherance of the scheme.

175. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

176. Data iSight communicated to Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could

1 not provide a basis for its unreasonably low allowed amount, mustering only that “it is  
2 just an amount that is recommended and sent over to United [HealthCare].”

3 177. Finally, after weeks of pressure, Data iSight informed Providers by phone  
4 that it would, after all, allow payment on the contested claims at a reasonable rate: 85%  
5 of billed charges.

6 178. In short, the Enterprise perpetuated its scheme by communicating threats  
7 regarding reimbursement cuts to Providers in late 2017 and 2018.

8 179. Then, after making good on those threats, the Enterprise communicated  
9 false and misleading information to Providers and falsely denied that it had information  
10 requested by Providers about the basis for the drastically-cut and unreasonable  
11 reimbursement rates that RICO Defendants sought to impose.

12 180. In addition, since at least January 1, 2019, the Enterprise has furthered this  
13 scheme by communicating payment amounts and making reimbursement payments to  
14 Providers at rates that were far below usual and customary rates and/or reasonable rates  
15 for the services provided.

16 181. For example, on March 5, 2019, RICO Defendants sent Plaintiffs, a  
17 Remittance for emergency services provided to Members under multiple procedure codes,  
18 including the following for CPT Codes 99284 and 99285:

19 f. Member #17 was treated on January 1, 2019 at a billed charge of  
20 \$1,190.00 (CPT Code 99284), for which RICO Defendants, via Data iSight, allowed  
21 \$413.39.

22 g. Member #18 was treated on January 30, 2019, at a billed charge of  
23 \$1,890.00 (CPT Code 99285), for which RICO Defendants, via Data iSight, allowed  
24 \$435.20.

25 h. Member #19 was treated on May 26, 2019, at a billed charge of  
26 \$862.00 (CPT Code 99285), for which RICO Defendants, via Data iSight, allowed  
27 \$291.86.  
28

1 i. Yet, Member #20 was treated on January 21, 2019, at a billed charge  
2 of \$1,190.00 (CPT Code 99284), for which RICO Defendants, via MultiPlan, allowed  
3 \$1,071.00 which is 90% of billed charges. This a reasonable rate, in line with the  
4 reasonable rates historically paid by RICO Defendants to Providers for non-participating  
5 provider services.

6 182. RICO Defendants and Data iSight expected that those unreasonable  
7 payments would be accepted in full satisfaction of Providers' claims.

8 183. RICO Defendants and Data iSight have received, and continue to receive,  
9 financial gains from their scheme to defraud Providers.

10 184. For the services that Providers provided to RICO Defendants' Members in  
11 2019, only 26% of the non-participating claims have, to date, been reimbursed at  
12 reasonable rates, resulting in millions of dollars in financial loss to Providers.

13 185. The purpose of, and the direct and proximate result of the above-alleged  
14 Enterprise and scheme was, and continues to be, to unlawfully reimburse Providers at  
15 unreasonable rates, to the harm of Providers, and to the benefit of the Enterprise.

## 16 **FIRST CLAIM FOR RELIEF**

### 17 **(Breach of Implied-in-Fact Contract)**

18 186. Providers incorporate herein by reference the allegations set forth in the  
19 preceding paragraphs as if fully set forth herein.

20 187. At all material times, Providers were obligated under federal and Arizona  
21 law to provide emergency medicine services to all Patients presenting at the emergency  
22 departments they staff, including Defendants' Members.

23 188. At all material times, Defendants were obligated to provide coverage for  
24 emergency medicine services to all of its Members. *See e.g.* A.R.S. § 20-2803.

25 189. At all material times, Defendants knew that Providers were non-  
26 participating emergency medicine groups that provided emergency medicine services to  
27 Patients.  
28

1           190. Providers have undertaken to provide emergency medicine services to  
2 Defendants' Members, and Defendants have undertaken to pay for such services provided  
3 to Defendants' Members.

4           191. At all material times, Defendants were aware that Providers were entitled  
5 to and expected to be paid at rates in accordance with the standards established under  
6 Arizona law.

7           192. At all material times, Defendants have received Providers' bills for the  
8 emergency medicine services Providers provided and continue to provide to Defendants'  
9 Members, and Defendants have consistently adjudicated and paid, and continues to  
10 adjudicate and pay, Providers directly for the non-participating claims, albeit at amounts  
11 less than usual and customary and/or reasonable rates.

12           193. Through the parties' conduct and respective undertaking of obligations  
13 concerning emergency medicine services provided by Providers to Defendants' Members,  
14 the parties implicitly agreed, and Providers had a reasonable expectation and  
15 understanding, that Defendants would reimburse Providers for non-participating claims  
16 at rates in accordance with the standards acceptable under Arizona law and in accordance  
17 with rates Defendants pay for other substantially identical claims also submitted by  
18 Providers.

19           194. Under Arizona common law, including the doctrine of quantum meruit,  
20 Defendants, by undertaking responsibility for payment to Providers for the services  
21 rendered to Defendants' Patients, impliedly agreed to reimburse Providers at rates, at a  
22 minimum, equivalent to the reasonable value of the professional emergency medical  
23 services provided by Providers.

24           195. Defendants, by undertaking responsibility for payment to Providers for the  
25 services rendered to Defendants' Members, impliedly agreed to reimburse Providers at  
26 rates, at a minimum, equivalent to the usual and customary rate or alternatively for the  
27 reasonable value of the professional emergency medical services provided by Providers.  
28

1           196. In breach of its implied contract with Providers, Defendants have and  
2 continues to unreasonably and systemically adjudicate the non-participating claims at  
3 rates substantially below both the usual and customary fees in the geographic area and the  
4 reasonable value of the professional emergency medical services provided by Providers  
5 to the Defendants' Patients.

6           197. Providers have performed all obligations under its implied contract with  
7 Defendants concerning emergency medical services to be performed for Patients.

8           198. At all material times, all conditions precedent have occurred that were  
9 necessary for Defendants to perform its obligations under their implied contract to pay  
10 Providers for the non-participating claims, at a minimum, based upon the "usual and  
11 customary fees in that locality" or the reasonable value of Providers' professional  
12 emergency medicine services.

13           199. Providers did not agree that the lower reimbursement rates paid by  
14 Defendants were reasonable or sufficient to compensate Providers for the emergency  
15 medical services provided to Patients.

16           200. Providers have suffered damages in an amount equal to the difference  
17 between the amounts paid by Defendants and the usual and customary fees professional  
18 emergency medicine services in the same locality, that remain unpaid by Defendants  
19 through the date of trial, plus Providers' loss of use of that money; or in an amount equal  
20 to the difference between the amounts paid by Defendants and the reasonable value of its  
21 professional emergency medicine services, that remain unpaid by Defendants through the  
22 date of trial, plus Providers' loss of use of that money.

23           201. As a result of Defendants' breach of the implied contract to pay Providers  
24 for the non-participating claims at the rates required by Arizona law, Providers have  
25 suffered injury and is entitled to monetary damages from Defendants to compensate it for  
26 that injury in an amount in excess of \$300,000.00, exclusive of interest, costs and  
27 attorneys' fees, the exact amount of which will be proven at the time of trial.  
28

**SECOND CLAIM FOR RELIEF**

**(Breach of the Implied Covenant of Good Faith and Fair Dealing)**

202. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

203. Providers and Defendants have a valid implied-in-fact contract as alleged herein.

204. A special element of reliance or trust between Providers and Defendants, such that, Defendants were in a superior or entrusted position of knowledge.

205. That Providers did perform all or substantially all of their obligations pursuant to the implied-in-fact contract.

206. By paying substantially low rates that did not reasonably compensate Providers the usual and customary rate or alternatively for the reasonable value of the services provided, Defendants performed in a manner that was unfaithful to the purpose of the implied-in-fact contract, or deliberately contravened the intention and spirit of the contract.

207. That Defendants' conduct was a substantial factor in causing damage to Providers.

208. As a result of Defendants' breach of the implied covenant of good faith and fair dealing, Providers have suffered injury and are entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of \$300,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

209. The acts and omissions of Defendants as alleged herein were attended by circumstances of malice, oppression and/or fraud, thereby justifying an award of punitive or exemplary damages in an amount to be proven at trial.

...

...

...

**THIRD CLAIM FOR RELIEF**

**(Alternative Claim for Unjust Enrichment)**

210. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein. This claim is pled in the alternative.

211. Providers rendered valuable emergency services to the Patients.

212. Defendants received the benefit of having their healthcare obligations to their plan Members discharged and their Members received the benefit of the emergency care provided to them by Providers.

213. As insurers or plan administrators, Defendants were reasonably notified that emergency medicine service providers such as Providers would expect to be paid by Defendants for the emergency services provided to Patients.

214. Defendants accepted and retained the benefit of the services provided by Providers at the request of the Members of its Health Plans, knowing that Providers expected to be paid a usual and customary fee based on locality, or alternatively for the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Members.

215. Defendants have received a benefit from Providers' provision of services to its Patients and the resulting discharge of its healthcare obligations owed to its Members.

216. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit it received without paying the value of that benefit; i.e., by paying Providers at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all emergency medicine services that Providers will continue to provide to Defendants' Members.

217. Providers seek compensatory damages in an amount which will continue to accrue through the date of trial as a result of Defendants' continuing unjust enrichment.

218. As a result of Defendants' actions, Providers have been damaged in an amount, exclusive of interest, costs and attorneys' fees, which will be proven at the time of trial.



219. Providers sue for the damages caused by Defendants' conduct and are entitled to recover the difference between the amount Defendants paid for emergency care Providers rendered to their Members and the reasonable value of the service that Providers rendered to Defendants by discharging its obligations to their plan members.

#### FOURTH CLAIM FOR RELIEF

**(Violation of A.R.S. § 20-442)**

220. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

221. Arizona law provides that “[n]o person shall engage in this state in any trade practice which is prohibited by this article, or defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.” A.R.S. § 20-442.

222. The acts and omissions detailed herein are violative of A.R.S. § 20-442.

223. By way of example only, Arizona law prohibits an insurer from engaging in unfair settlement practices. A.R.S. § 20-461. Prohibited unfair claim settlement practices include: (1) “Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” A.R.S. § 20-461(A)(6); and (2) “Failing to promptly provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.” A.R.S. § 20-461(A)(14).

224. As detailed above, Defendants have failed to comply with A.R.S. § 20-461 by failing to pay Providers' medical professionals the usual and customary rate for emergency care provided to Defendants' members. By failing to pay Providers' medical professionals the usual and customary rate Defendants have violated Arizona law and committed an unfair settlement practice.

225. Providers are therefore entitled to recover the difference between the amount Defendants paid for emergency care Providers rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.



226. Providers are entitled to damages in an amount, exclusive of interest, costs and attorneys' fees, that will be proven at the time of trial.

227. Defendants have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, Providers are entitled to recover punitive damages against Defendants.

## **FIFTH CLAIM FOR RELIEF**

### **(Violation of AZ Consumer Fraud Statute)**

228. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

229. The Arizona Consumer Fraud Statute prohibits Defendants from engaging in “any deception, deceptive or unfair act or practice, fraud, false pretense, false promise, misrepresentation, or concealment, suppression or omission of any material fact with intent that others rely on such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice.” A.R.S. § 44-1522.

230. The Arizona Consumer Fraud Statute provides for a private right of action.

231. Defendants have violated the AZ Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay Providers for the medically necessary, covered emergency services Providers provided to Members in order to gain unfair leverage against Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Providers to accept lower amounts than it is entitled for their services; (b) engaging in systematic efforts to delay adjudication and payment of Providers’ claims for their services provided to Defendants’ members in violation of Defendants’ legal obligations; and (c) misrepresenting that the use of Data iSight for its claims processing was founded on

1 transparent actual statistically sound data, rates that are defensible and market tested and  
2 geographically based.

3 232. As a result of Defendants' violations of the Consumer Fraud Statute, the  
4 Providers are entitled to damages in an amount to be determined at trial.

5 233. Due to the willful and knowing engagement in consumer fraud practices,  
6 the Providers are entitled to recover damages, including statutory civil penalties permitted  
7 under § 44-1522 or otherwise, and all profits derived from the knowing and willful  
8 violation.

### 9 SIXTH CLAIM FOR RELIEF

#### 10 (Declaratory Judgment)

11 234. Providers incorporate herein by reference the allegations set forth in the  
12 preceding paragraphs as if fully set forth herein.

13 235. This is a claim for declaratory judgment and actual damages pursuant to  
14 A.R.S. 12-1831 *et seq.*

15 236. As explained above, pursuant to federal and Arizona law, Defendants are  
16 required to cover and pay Providers for the medically necessary, covered emergency  
17 medicine services Providers have provided and continues to provide to Defendants'  
18 members.

19 237. Under Arizona law, Defendants are required to pay Providers the usual and  
20 customary rate for that emergency care. Instead of reimbursing Providers at the usual and  
21 customary rate or for the reasonable value of the professional medical services,  
22 Defendants has reimbursed Providers at reduced rates with no relation to the usual and  
23 customary rate.

24 238. As alleged herein, Providers became out-of-network with the Defendants.  
25 Since then, Defendants have demonstrated their refusal to timely settle insurance claims  
26 submitted by Providers and has failed to pay the usual and customary rate based on this  
27 locality in violation of Defendants' obligations under the Arizona Insurance Code, the  
28

1 parties' implied-in-fact contract and pursuant to Arizona law of unjust enrichment and  
2 quantum merit.

3 239. An actual, justiciable controversy therefore exists between the parties  
4 regarding the rate of payment for Providers' emergency care that is the usual and  
5 customary rate that Defendants are obligated to pay.

6 240. Pursuant to A.R.S. 12-1831 *et seq.*, Providers therefore request a  
7 declaration establishing the usual and customary rates that Providers are entitled to  
8 receive for all claims at up to and through trial, as well as a declaration that Defendants  
9 are required to pay to Providers at a usual and customary rate for claims submitted  
10 thereafter.

### 11 SEVENTH CLAIM FOR RELIEF

#### 12 (Violation of A.R.S. § 13-2314.04 - RICO Defendants)

13 241. Providers incorporate herein by reference the allegations set forth in the  
14 preceding paragraphs as if fully set forth herein.

15 242. Arizona law allows for a private cause of action for injury resulting from a  
16 pattern of unlawful activity. A.R.S. § 13-2301 *et seq.* Specifically, A.R.S. § 13-  
17 2314.04(A) provides that:

18 A person who sustains reasonably foreseeable injury to his  
19 person, business or property by a pattern of racketeering  
20 activity, or by a violation of § 13-2312 involving a pattern of  
21 racketeering activity, may file an action in superior court for  
22 the recovery of up to treble damages and the costs of the suit,  
including reasonable attorney fees for trial and appellate  
representation.

23 243. "Racketeering" includes, among things, any act or preparatory act  
24 committed for financial gain, chargeable or indictable under the law where the act  
25 occurred and punishable by more than a year's imprisonment. A.R.S. § 13-2301(D)(4)(b).

26 244. A pattern of unlawful activity includes, among other things, a person who  
27 engages in illegally controlling an enterprise and a scheme or artifice to defraud that  
28 results in knowingly obtaining a financial benefit by means of false or fraudulent

1 pretenses, representations, promises or material omissions. A.R.S. § 13-  
2 2301(D)(4)(b)(xv); A.R.S. § 13-2310; A.R.S. § 13-2312.

3 245. A “pattern of racketeering activity” means, among things, that there must  
4 be at least two related and continuous acts of “racketeering” defined in § 13-2301(D)(4),  
5 including, but not limited to, item (xv). A.R.S. § 13-2314.04(T)(3)(a). Additionally, a  
6 pattern of unlawful activity requires relatedness, continuity and occurrence within five  
7 years of one another.

8 246. Since at least January 2019, Providers sustained reasonably foreseeable  
9 injury to their business by a pattern of unlawful activity and/or by violation of A.R.S §  
10 13-2312 involving a pattern of unlawful activity.

11 247. Providers are a “person” within the meaning of A.R.S. § 13-2314.04(A).

12 248. The RICO Defendants are a “person” within the meaning of A.R.S. § 13-  
13 2310.

14 249. Since at least January 2019, the RICO Defendants, have been and continue  
15 to be, engaged in preparations and implementation of a scheme to defraud Providers by  
16 committing a series of unlawful acts designed to obtain a financial benefit by means of  
17 false or fraudulent pretenses, representations, promises or material omissions which  
18 constitute predicate unlawful activity under A.R.S. § 13-2310, in violation of in violation  
19 of A.R.S. § 13-2314.04. The RICO Defendants have engaged in more than two related  
20 and continuous acts amounting to a pattern of unlawful activity pursuant to a scheme or  
21 artifice to defraud and to which the RICO Defendants have committed for financial  
22 benefit and gain to the detriment of Providers. The RICO Defendants, on more than two  
23 occasions, have schemed with Data iSight to artificially and without foundation  
24 substantially decrease non-participating provider reimbursement rates while continuing  
25 to represent that the reimbursement rates are based on legitimate cost data or paid data.

26 250. The foregoing acts establish a pattern of unlawful activity are related to each  
27 other in that they further the joint goal of unfairly and illegally retaining financial benefit  
28 to the detriment of Providers. In each of the examples provided herein, the acts alleged

1 to establish a pattern of unlawful activity are related because they have the same or similar  
2 purposes, results, participants, victims and/or methods of commission.

3 251. Since at least January 2019, RICO Defendants have been and continue to  
4 be, a part the Enterprise within the meaning of A.R.S. § 13-2301(D)(2), comprised the  
5 RICO Defendants and Data iSight, and which Enterprise was and is illegally controlled  
6 by the RICO Defendants and/or being illegally conducted through a pattern of unlawful  
7 activity or participating directly or indirectly in the conduct of the Enterprise.

8 252. Each of the RICO Defendants has an existence separate and distinct from  
9 the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

10 253. RICO Defendants and Data iSight had, and continue to have, the common  
11 and continuing purpose of dramatically reducing allowed provider reimbursement rates  
12 for their own pecuniary gain, by defrauding Providers and preventing Providers from  
13 obtaining reasonable payment for the services they provided to RICO Defendants'  
14 Members, in retaliation for Providers' lawful refusal to agree to RICO Defendants'  
15 massively discounted and unreasonable proposed contractual rates.

16 254. Each RICO Defendant provides benefits to insured members, processes  
17 claims for services provided to members, and/or issues payments for services and knows  
18 and willingly participates in the scheme to defraud Providers.

19 255. As a direct and proximate result of RICO Defendants' violations of A.R.S.  
20 § 13-2314.04, Providers have sustained a reasonably foreseeable injury in their business  
21 by a pattern of unlawful activity, suffering direct and substantial financial losses within  
22 the meaning of A.R.S. § 13-2314.04. Specifically, but for the unlawful acts of the RICO  
23 Defendants in falsely representing the validity of Data iSight statistical data, Providers  
24 would not have suffered the loss of millions of dollars in underpaid claims which the  
25 RICO Defendants repeatedly represented were reasonable/usual and customary rates of  
26 payment.

27 256. RICO Defendants have been and continue to be, a part of an enterprise  
28 within the meaning of A.R.S. § 13-2301(D)(2).

257. The RICO Defendants have and are illegally controlling the Enterprise by acquiring or maintaining, by investment or otherwise, control of any enterprise through a pattern of unlawful activity or their proceeds; and/or illegally conducting an enterprise, i.e., a person employed by or associated with enterprise is conducting the affairs of the Enterprise through a pattern of unlawful activity or participating directly or indirectly in the conduct of any enterprise that the person knows is being conducted through a pattern of unlawful activity. A.R.S. § 13-2312(A)-(B).

258. For purposes of A.R.S. § 13-2301(D)(1), the RICO Defendants “control” the Enterprise because they possess sufficient means to permit substantial direction over the affairs of the Enterprise. A.R.S. § 13-2301(D)(1).

259. As an Enterprise that acquired financial benefit or property through violation of A.R.S. § 13-2312, the RICO Defendants are involuntary trustees, and the involuntary trustees, must hold the property, their proceeds and their fruits in constructive trust for the benefit of persons entitled to remedies under A.R.S. § 13-2314.04. A.R.S. § 13-2314.04(D)(6).

260. Providers are entitled to damages in an amount, exclusive of interest, costs and attorneys' fees, that will be proven at the time of trial.

261. Providers are entitled to treble damages and the costs of the suit, including reasonable attorney fees for trial and appellate representation pursuant to A.R.S. § 13-2314.04.

### PRAYER FOR RELIEF

WHEREFORE, Providers pray for judgment as follows:

- A. Judgment in their favor on their First Amended Complaint;
- B. Awards of actual, consequential, general, and special damages in an amount which will be proven at trial;
- C. An award of punitive damages, the exact amount of which will be proven at trial;

1 D. A declaratory judgment that Defendants' failure to pay Providers a usual  
2 and customary fee or rate for this locality or alternatively, for the reasonable value of their  
3 services, violates Arizona law, breaches the parties' implied-in-fact contract, is a tortious  
4 breach of the implied covenant of good faith and fair dealing, and violates Arizona  
5 common law;

6 E. An order permanently enjoining Defendants from paying rates that do not  
7 represent usual and customary fees or rates for this locality or alternatively, that do not  
8 compensate Providers for the reasonable value of their services; and enjoining Defendants  
9 from engaging in acts or omissions that are violative of Arizona law;

10 F. Judgment against the RICO Defendants and in favor of Providers pursuant  
11 to the Seventh Claim for Relief in an amount constituting treble damages resulting from  
12 Defendants' underpayments to Providers for the reasonable value of the emergency  
13 services provided to Defendants' Members and reasonable attorneys' fees and costs  
14 incurred in bringing this action;

15 G. Providers' costs and reasonable attorneys' fees pursuant to A.R.S. §§ 12-  
16 341 and 12-341.01;

17 H. Pre-judgment and post-judgment interest at the highest rates permitted by  
18 law; and

19 I. Such other and further relief as the Court may deem just and proper.

### 20 JURY DEMAND

21 Providers hereby demand trial by jury on all issues so triable.

22 DATED this 9th day of August, 2019.

23 McDONALD CARANO LLP

24 By: /s/ Pat Lundvall

25 Pat Lundvall (admitted *pro hac vice*)

26 Kristen T. Gallagher (admitted *pro hac vice*)

27 Amanda M. Perach (admitted *pro hac vice*)

28 Douglas F. Behm - 014727

*Attorneys for Plaintiffs*



**VERIFICATION PURSUANT TO A.R.S. § 13-2314.04(O)**

Under penalties of perjury, the undersigned declares that he is a representative of the Plaintiffs named in the foregoing First Amended Complaint and knows the contents thereof; that the pleading is true of his knowledge, except as to those matters stated on information and belief, and that as to such matters he believes it to be true.

Executed: August 9, 2019.

  
Kent Bristow



**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of August 2019, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via the U.S. District Court's CM/ECF filing system and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

John C. West, Esq.  
Nicole G. True, Esq.  
LEWIS ROCA ROTHGERBER CHRISTIE LLP  
201 East Washington Street  
Suite 1200  
Phoenix, AZ 85004  
JWest@lrrc.com  
NTrue@lrrc.com

*Attorneys for Defendants UnitedHealthcare, Inc.,  
UnitedHealthcare Services Inc., UMR, Inc.,  
Unitedhealthcare Integrated Services, Inc., and  
Unitedhealthcare Specialty Benefits, LLC*

/s/ Marianne Carter  
An employee of McDonald Carano LLP

# Exhibit 29



O'Melveny & Myers LLP  
1625 Eye Street, NW  
Washington, D.C. 20006

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F: +1 212 326 2061  
omm.com

January 23, 2024

Greg Jacob  
+1 202 383-5110  
gjacob@omm.com

**VIA EMAIL AND FEDEX**

Kent Bristow  
Senior Vice President, Revenue Mgmt.  
TeamHealth Holdings, Inc.  
265 Brookview Centre Way, Suite 203  
Knoxville, TN 37919

James W. Cobb  
Cameron B. Roberts  
CAPLAN COBB LLC  
75 Fourteenth Street, NE, Suite 2700  
Atlanta, Georgia 30309

**Re: United Healthcare Services, Inc. v. Hospital Physician Services Southeast P.C.**

Dear Mr. Bristow,

We represent United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR Inc. (collectively, "United") in the above captioned litigation—*United Healthcare Services Inc., et al. v. Hospital Physician Services Southeast, P.C. et al.*, Case No. 1:23-cv-05221-JPB—which is currently pending in the Northern District of Georgia (the "Georgia lawsuit"). You recently signed a declaration in support of Defendants' Motion to Dismiss the Complaint, ECF No. 23 ("Motion to Dismiss"), which I attach for your reference (the "Bristow Decl.>").

In paragraph 8 of your declaration you state that: "[p]resently, the Georgia Medical Groups<sup>1</sup> have no intent to take legal action against United regarding the Litigation Medical Claims." Bristow Decl. ¶ 8, ECF 23-1. This statement is repeated in Defendants' Motion to Dismiss in support of the argument that there is no controversy between United and the Georgia Medical Groups. See Motion to Dismiss at 13–14. Relying on your statements, Defendants claim that "any proffered controversy between the Georgia Medical Groups and United is 'conjectural' and 'hypothetical' rather than 'real and immediate.'" *Id.* at 14.

It is of course preferable to United to be able to resolve the ongoing dispute between the parties concerning the legally required standard for payment of claims without further litigation. It is essential to United's role as an administrator of ERISA-governed health benefit plans and payor of claims that United have certainty that it should be adjudicating plan benefits by applying plan terms, rather than some state common law standard that is external to the plans.

TeamHealth threatened United in 2019 that "[w]e've gotten really good at the litigation route and have a template to file in every state for every contract," and that [f]or every UHG termination,

---

<sup>1</sup> Your declaration uses the term "Georgia Medical Groups" to refer to the Defendants in the Georgia Lawsuit—Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C.



we'll file a TeamHealth lawsuit." For the last several years, TeamHealth has doggedly been making good on those threats, filing eleven lawsuits against United since 2019, including two new lawsuits that it filed in Florida in November 2023. And as you are aware, two of the Georgia Defendants were parties to one of the TeamHealth contracts that United terminated by letter dated July 9, 2019. TeamHealth has already filed lawsuits against United in four of the six states in which that set of contracts was terminated, and it is untenable for United to continue to adjudicate claims in Georgia under the continued threat that where United has adjudicated health plan benefits consistent with plan terms, TeamHealth will sue United asserting that it should instead have paid the claims in accordance with a state common law standard external to the plans.

Based on the declaration in support of Defendants' Motion to Dismiss the Complaint, it appears that TeamHealth may be willing to retract its prior threats and forswear challenging United's adjudication of the claims at issue in the Georgia lawsuit using common law theories. If that is the case, we ask that that you memorialize this understanding by executing the attached declaration on the Georgia Defendants' behalf, affirming that Georgia Defendants will not sue United Healthcare or any United affiliates using state common law causes of action to seek increased payments on any of the claims at issue in the Georgia lawsuit.<sup>2</sup> By executing the declaration, the Georgia Defendants would retain the right to bring (with appropriate patient authorization) administrative appeals challenging plan benefit determinations or ERISA benefit claims in federal court, which are designed to enforce ERISA's bedrock requirement that health plan benefit claims be adjudicated in accordance with plan terms.

We respectfully request that you respond to this letter by noon on January 26, 2024. If we do not receive a response by that date, we will assume that you are unwilling to execute the attached declaration. Thank you.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Greg Jacob', with a stylized flourish at the end.

Greg Jacob

---

<sup>2</sup> The Georgia Lawsuit involves claims for medical services rendered by the Georgia Medical Group in Georgia for (i) out-of-network emergency services provided to United's members prior to January 1, 2022 and (ii) claims for out-of-network non-emergency services provided to United's members on or after January 1, 2022.

# Exhibit 30



SENDER'S E-MAIL: jfineberg@lashgoldberg.com  
REPLY TO MIAMI OFFICE

January 29, 2024

**VIA EMAIL**

Greg Jacob  
O'Melveny & Myers LLP  
1625 Eye Street NW  
Washington, D.C. 20006  
gjacob@omm.com

**Re: United Healthcare Services, Inc. v. Hospital Physician Services Southeast P.C.**

Dear Mr. Jacob:

We write in response to your January 23, 2024 letter to Kent Bristow ("Letter"). In the Letter, you reference a declaration ("Declaration") that Mr. Bristow executed in support of Defendants' Motion to Dismiss for Lack of Subject-Matter Jurisdiction ("Motion") in the above-captioned case.<sup>1</sup> As you acknowledge, Mr. Bristow attested in his Declaration that "[p]resently, the Georgia Medical Groups have no intent to take legal action against United regarding the Litigation Medical Claims."<sup>2</sup> (Decl. ¶ 8.) As Defendants explain in the Motion, this reality poses an insurmountable hurdle to United's effort to obtain declaratory relief. Under longstanding, well-established law, the courts of the United States are not constitutionally empowered to render advisory opinions or otherwise adjudicate hypothetical disputes. Put simply, the Court has no subject-matter jurisdiction and must dismiss this case.

Apparently recognizing this reality, you now ask Mr. Bristow to "memorialize this understanding by executing the attached declaration ... affirming that [the Georgia Medical Groups] will not sue [United] using state common law causes of action to seek increased payments on any of the claims at issue in the Georgia lawsuit...." (Letter at 2.) Mr. Bristow will respectfully decline that invitation for several reasons:

---

<sup>1</sup> The Motion is ECF No. 23. The Declaration is ECF No. 23-1.

<sup>2</sup> The "Georgia Medical Groups" are the Defendants in the above-captioned matter. The "Litigation Medical Claims" are defined in ¶ 6 of the Declaration. They include "(a) out-of-network emergency services provided by the Georgia Medical Groups to United's members prior to January 1, 2022 in Georgia, and (b) claims for out-of-network non-emergency services provided to United's members at out-of-network facilities on or after January 1, 2022 in Georgia."

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954.384.2510

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142 West Platt St., Ste.118  
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813.284.4002

January 29, 2024

Page 2

*First*, there is no need for an additional sworn statement because Mr. Bristow's existing Declaration is clear and unambiguous. Mr. Bristow attests that "[p]resently, the Georgia Medical Groups have no intent to take legal action against United regarding the Litigation Medical Claims." That statement means precisely what it says: **presently**, the Georgia Medical Groups do not intend to sue United regarding the Litigation Medical Claims. If Mr. Bristow had meant to declare that the Georgia Medical Groups were making an ironclad commitment to **never** sue United, he would have done so.

*Second*, your request for the Georgia Medical Groups to commit to never suing United is entirely unreasonable. As Mr. Bristow explains, "TeamHealth-affiliated medical groups ... are selective and deliberate about whether and when to take legal action against Insurers." (Decl. ¶ 10.) These decisions are influenced by a variety of external factors, including market conditions in a given geography. Thus, Mr. Bristow's statement should be understood for what it plainly is: an expression of present intent based on the current status quo. Of course, should conditions change at some point in the future, it is possible that intentions could change in response. But all of this is purely speculative, and it serves only to highlight that any perceived dispute between the Georgia Medical Groups and United is "conjectural, hypothetical, or contingent," rather than "real and immediate." *Malowney v. Fed. Collection Deposit Grp.*, 193 F.3d 1342, 1347 (11th Cir. 1999).

*Third*, we suspect your Letter is not a good faith attempt to resolve a dispute between the parties, but rather is an effort to manufacture a record you can use to support United's eventual response to the Georgia Medical Groups' upcoming motion to dismiss the Amended Complaint. In other words, we expect that United will argue to the Court that the Georgia Medical Groups' refusal to commit to never suing, irrespective of whatever unforeseen circumstances may materialize in the future, somehow suggests that there is a present, justiciable controversy for the Court to resolve. While United is free to make whatever arguments it deems appropriate, we note that such a position would reflect a gross misstatement of the governing legal standard.

*Finally*, you state that "[i]t is of course preferable to United to be able to resolve the ongoing dispute between the parties concerning the legally required standard for payment of claims without further litigation." (Letter at 1.) We note once again that there is, in fact, no "ongoing dispute between the parties," because the Georgia Medical Groups do not presently intend to sue United regarding reimbursement amounts on the claims that United has put at issue in this lawsuit, and they have given no indication to the contrary. And while we certainly appreciate United's expressed preference to avoid further litigation, that sentiment is belied by United's actions to date. Notably, United initiated this case without making any pre-suit effort to discuss the issues raised or otherwise ascertain whether the Georgia Medical Groups intended to sue it. If United sincerely wishes to avoid unnecessary litigation, then it should drop its meritless lawsuit.

Sincerely,

LASHGOLDBERG LLP

/s/ Justin C. Fineberg  
Justin C. Fineberg



January 29, 2024  
Page 3

cc: All Counsel



**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,  
INC.; UNITED HEALTHCARE  
INSURANCE COMPANY; AND UMR,  
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES  
SOUTHEAST, P.C.; INPHYNET  
PRIMARY CARE PHYSICIANS  
SOUTHEAST, P.C.; AND REDMOND  
ANESTHESIA & PAIN TREATMENT,  
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-  
JPB

**DECLARATION OF JOAO C. DOS SANTOS**

**April 11, 2025**

## I. INTRODUCTION & QUALIFICATIONS

1. I, Joao C. dos Santos, have been retained by Plaintiffs United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. ("United") to aggregate information from claims data produced by Plaintiffs in the above-referenced dispute with Defendants: Hospital Physician Services Southeast, P.C., InPhyNet Primary Care Physicians Southeast P.C., and Redmond Anesthesia & Pain Treatment, P.C. ("Defendants").

2. I am an economist and Senior Managing Director in Ankura's Global Disputes and Economics practice and a leader in the firm's Healthcare Services group. With respect to healthcare data and processes, I have worked for over two decades on numerous disputes and strategic management matters requiring the processing and analysis of complex structured and unstructured healthcare claims data. I hold a Master of Science degree in applied economics from Rutgers University, with field concentrations including complex data analysis, econometrics, and statistics. I am active in several professional societies relevant to my profession, including the American Economic Association and the American Statistical Association. I regularly attend conferences and seminars and accrue continuing professional education credits on topics related to selected industries and academic fields, including healthcare, economics, and data science. **Attachment 1** is a copy of my CV.

3. The work on this matter was performed personally by me or by professionals working directly under my supervision. Ankura is being compensated at the rate of \$775 per hour for my time on this matter. Compensation paid to Ankura is not contingent upon any action or event resulting from the calculations included herein.

4. The data I have relied on are detailed within this declaration. I filtered the data as outlined in this declaration based on the information currently available to me.

## II. ASSIGNMENT

5. In this declaration, I was asked by Counsel for United to (i) identify a set of claims in dispute in this matter using claims data provided by United and criteria provided to me by Counsel; and (ii) identify the ten plans with the greatest volume of disputed claims represented in the set of disputed claims I identified from the UNET claim platform (which comprises the majority of the disputed claims).

## III. STEPS EMPLOYED TO IDENTIFY CLAIMS AND PLANS

### A. Identification of Disputed Claims and Amounts in Dispute

6. I received a set of claims data files from United via Counsel which contained professional claims submitted to United for reimbursement for services rendered by TeamHealth providers to United's members with dates of service between July 1, 2018 through April 20, 2024 ("United's Claims Data").<sup>1</sup> This

<sup>1</sup> These claims data files included the following outlined by claims platform:

UNET Archive: Legal\_TeamHealth\_DJ\_Jul2019\_Dec2019\_UNET.xlsx;  
 UNET Live: lgl\_US7195822\_Unet\_Y2020\_1\_No SSN.csv, lgl\_US7195822\_Unet\_Y2020\_2\_No SSN.csv, lgl\_US7195822\_Unet\_Y2020\_3\_No SSN.csv, lgl\_US7195822\_Unet\_Y2021\_1\_No SSN.csv, lgl\_US7195822\_Unet\_Y2021\_2\_No SSN.csv, lgl\_US7195822\_Unet\_Y2021\_3\_No SSN.csv, lgl\_US7195822\_Unet\_Y2022\_1\_No SSN.csv, lgl\_US7195822\_Unet\_Y2022\_2\_No SSN.csv, lgl\_US7195822\_Unet\_Y2022\_3\_No SSN.csv, lgl\_US7195822\_Unet\_Y2022\_4\_No SSN.csv, lgl\_US7195822\_Unet\_Y2023\_1\_No SSN.csv, lgl\_US7195822\_Unet\_Y2023\_2\_No SSN.csv, lgl\_US7195822\_Unet\_Y2023\_3\_No SSN.csv, lgl\_US7195822\_Unet\_Q1Y2024\_1\_No SSN.csv, lgl\_US6576478\_ED\_Unet\_2021\_2\_NO SSN.csv, lgl\_US6576478\_ED\_Unet\_2022\_2\_NO SSN.csv, lgl\_US6576478\_HM\_Acute\_PAC\_Unet\_2021\_1\_NO SSN.csv, lgl\_US6576478\_HM\_Acute\_PAC\_Unet\_2022\_1\_NO SSN.csv, lgl\_APM2509\_Unet\_ANES\_Q32019\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q32019\_1.csv, lgl\_APM2509\_Unet\_ANES\_Q42019\_1.csv, lgl\_APM2509\_Unet\_ED\_Q42019\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q42019\_1.csv, lgl\_APM2509\_Unet\_ED\_Q12020\_1.csv,

data includes extracts from United's claims platforms including (1) UNET (both live data and archive platforms), (2) UMR and (3) Oxford. I describe the steps that I took to filter the United Claims Data to a set of claims that I understand, based on information from Counsel, to be subject to this dispute.

7. The Defendants consist of the following TeamHealth providers who are all organized under the laws of the State of Georgia: (i) Hospital Physician Services Southeast, P.C. (TIN: 20-3566888) is a hospitalist medical care provider<sup>2</sup>; (ii) InPhyNet Primary Care Physicians Southeast P.C. (TIN: 65-0203499) is an emergency medical care provider<sup>3</sup>; and (iii) Redmond Anesthesia & Pain Treatment, P.C. (TIN: 45-5230550) is a pain medicine and anesthesiology medical care provider.<sup>4</sup>

8. First, I filtered the United's Claims Data to limit to claims for services provided by Defendants based on tax ID number (TIN) and excluded all other providers.<sup>5</sup> **Table 1** shows the results of the initial filtering I performed to limit United's Claims Data to the Defendant providers and then a breakdown of the United's Claims Data for the Defendant providers by claims platform.

**Table 1: United Claims Data by Platform**

|                                                     | Claims        | Lines          | Charges <sup>6</sup> | Allowed <sup>7</sup> |
|-----------------------------------------------------|---------------|----------------|----------------------|----------------------|
| United's Claims Data                                | 5,822,230     | 9,192,653      | \$6,719,564,614      | \$1,676,935,776      |
| <i>Less: Non-Defendant Providers</i>                | 5,726,243     | 9,069,657      | \$6,655,990,285      | \$1,657,554,687      |
| <b>United's Claims Data for Defendant Providers</b> | <b>95,987</b> | <b>122,996</b> | <b>\$63,574,329</b>  | <b>\$19,381,089</b>  |
| UNET Live                                           | 58,984        | 78,447         | \$38,532,146         | \$8,864,684          |
| UNET Archive                                        | 18,912        | 23,577         | \$12,062,353         | \$5,160,955          |
| UMR                                                 | 16,239        | 17,731         | \$11,892,037         | \$5,024,356          |
| Oxford                                              | 1,852         | 3,241          | \$1,087,793          | \$331,095            |

9. After limiting to the Defendant providers, I then performed the following additional steps to further filter United's Claims Data to exclude claims that I understand from Counsel are not subject to this dispute. The filters that I applied and the steps I took to perform this filtering are as follows:

- i. Pre-Statute of Limitations Period: Counsel instructed me to include in the disputed claims set only those claims having dates of service within the five-year period preceding July 1, 2024. I

lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q12020\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q22020\_1.csv, lgl\_APM2509\_Unet\_ED\_Q32020\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q32020\_1.csv, lgl\_APM2509\_Unet\_ED\_Q12021\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q12021\_1.csv, lgl\_APM2509\_Unet\_ED\_Q22021\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q22021\_1.csv, lgl\_APM2509\_Unet\_ED\_Q32021\_1.csv, lgl\_APM2509\_Unet\_ED\_Q22022\_1.csv, lgl\_APM2509\_Unet\_ED\_Q32022\_1.csv, lgl\_APM2509\_Unet\_HM\_Acute\_PAC\_Q42022\_1.csv;

UMR: United TH Fed Dec Judg UMR Data 2018 2021 file.xlsx, United TH Fed Dec Judg UMR Data 2022 2024 file.xlsx; and Oxford: Legal\_Team\_Health\_CRR\_Jul2018\_Mar2024.xlsx.

<sup>2</sup> Complaint ¶ 18.

<sup>3</sup> Complaint ¶ 19.

<sup>4</sup> Complaint ¶ 20.

<sup>5</sup> The provider TIN fields in United's Claims Data are the following: UNET Archive – ADJD\_PROV\_TIN, UNET Live – ServicingProviderTIN, UMR – ProviderTIN, Oxford – ADJD\_PROV\_TIN.

<sup>6</sup> The charge amount fields in United's Claims Data are the following: UNET Archive – CHRG\_AMT, UNET Live – Billed\_Charges, UMR – ChargeAmount, Oxford – CHRG\_AMT.

<sup>7</sup> The allowed amount fields in the United's Claims Data are the following: UNET Archive – ALLWD\_AMT, UNET Live – Allowed\_Amount, UMR – AllowedAmount, Oxford – ALLWD\_AMT.

therefore excluded claims from United's Claims Data with dates of service that preceded July 1, 2019.<sup>8</sup>

- ii. Denied Claims: I understand from Counsel that claims for which coverage by a United benefit plan was denied are not subject to this dispute. I therefore excluded any claims from United's Claims Data with a zero or negative allowed amount.
- iii. Rental Network Claims: I understand from Counsel that claims that were adjudicated pursuant to a rental network agreement are not subject to this dispute and I therefore excluded rental network claims. I used the UNET and Oxford reason code fields<sup>9,10</sup> and the UMR Network Description fields in United's Claims Data to identify and exclude rental network claims.
- iv. Participating Claims: I understand from Counsel that claims for which the TeamHealth Defendants have a contract with United are not subject to this dispute. I therefore excluded such "participating" claims.<sup>11</sup> I identified participating claims based on the par status field<sup>12</sup> in United's Claims Data and based on information included in the Complaint concerning the contract effective dates for the Defendant providers and excluded these participating claims from United's Claims Data.<sup>13</sup>
- v. HMO Claims: I understand from Counsel that HMO claims are not subject to this dispute. I identified and excluded HMO claims from United's Claims Data based on the plan product field.<sup>14</sup>
- vi. Fully Insured Indemnity Claims: I understand from Counsel that fully insured claims identified as subject to indemnity plan coverage are not subject to this dispute. I identified and excluded these claims from United's Claims Data based on the financial arrangement field and the plan product field.<sup>15</sup>

<sup>8</sup> The date of service fields in the United's Claims Data are the following: UNET Archive – *ERLY\_SRVC\_DT*, UNET Live – *DOS\_Begin*, UMR – *ServiceDate*, Oxford – *ERLY\_SRVC\_DT*.

<sup>9</sup> The reason code fields in the United's Claims Data are the following: UNET Archive – *SRC\_CLM\_RSN\_CD*, UNET Live – *ReasonCode*, Oxford – *SRC\_CLM\_RSN\_CD*.

<sup>10</sup> I identified rental network claims in United's Claims Data based on the following reason codes: "FV" (description includes: *THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON AN AGREEMENT WITH BEECH STREET.*); "IM" (description: *THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON AN AGREEMENT WITH GALAXY HEALTH.*); "IT" (description: *THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON AN AGREEMENT WITH MULTIPLAN.*); "IX" (description: *THIS PHYSICIAN OR HEALTH CARE PROVIDER IS OUT-OF-NETWORK. BASED ON A FEE NEGOTIATED AGREEMENT WITH MULTIPLAN/VIANT, THE PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE.*); "UE" (description: *THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON AN AGREEMENT WITH HEALTHSMART/HPO.*); "SSPMPL" (description: *THIS SERVICE WAS PAID AT THE MULTIPLAN CONTRACTED RATE.*).

<sup>11</sup> "This lawsuit concerns those claims for benefits only, and does not seek any relief with respect to claims for benefits for which the reimbursement amount is determined by an agreement with the TeamHealth Defendants" (Complaint ¶ 6).

<sup>12</sup> I identified participating claims in United's Claims Data based on the following fields / values: UNET Archive – *NTWK\_IND* (value: "I"), UNET Live – *ParStatus* (value: "Y"), UMR – *NetworkInd* (value: "P"), Oxford – *NTWK\_IND* (value: "I").

<sup>13</sup> I also understand that two of the Defendants: Hospital Physicians Services Southeast, P.C. and Redmond Anesthesia & Pain Treatment P.C. were previously parties to a network participation agreement which was terminated effective October 15, 2019 (Complaint ¶ 44).

<sup>14</sup> I identified HMO claims in United's Claims Data based on the following fields / values: UNET Archive – *Product\_Code* (value: "HMO"), UNET Live – *Plan\_Product* (value: "HMO"), Oxford – *Product\_Code* (value: "HMO").

<sup>15</sup> I identified fully insured claims in United's Claims Data based on the following fields / values: UNET Archive – *FUND\_ARNG\_CD* (value: "FI") and UNET Live – *Financial Arrangement* (values: "FULLY INSURED" or "MP/MMP"); note that UMR only adjudicates ASO claims. I identified indemnity claims in United's Claims Data based on the following fields / values: UNET *Plan Product* field and the UNET Archive *Product\_Code* field with the value "IND".

- vii. Single Case Agreement Claims: I understand from Counsel that claims negotiated under single case agreements<sup>16</sup> are not subject to this dispute. I identified and excluded these claims from United's Claims Data based on the reason code field.<sup>17</sup>
- viii. Commercial Not Primary Payor Claims: I understand from Counsel that claims for which United benefit plans belonging to United's commercial line of business are not the primary payor (e.g., where a Medicare managed care plan is the primary payor) are not subject to this dispute. As a precautionary exclusion, I identified and excluded these claims from United's Claims Data based on the reason code field.<sup>18</sup>
- ix. Non-Final Claim Lines: I removed any non-final claim lines included in United's Claims Data.<sup>19</sup>
- x. Non-ERISA Claims: I understand from Counsel that this dispute relates to claims that United processes on behalf of plans that are subject to ERISA.<sup>20</sup> I identified and removed non-ERISA claims from United's Claims Data using the ERISA field.<sup>21</sup>
- xi. Federal NSA Claims: I understand from Counsel, and from reviewing the Complaint, that claims that are subject to the dispute-resolution provisions of the federal No Surprises Act ("NSA") are not subject to this dispute.<sup>22</sup> The NSA "generally applies to claims for emergency services, and to claims for services delivered by out-of-network providers at network hospitals

<sup>16</sup> "This lawsuit concerns those claims for benefits only, and does not seek any relief with respect to claims for benefits for which the reimbursement amount is determined by an agreement with the TeamHealth Defendants" (Complaint ¶ 6).

<sup>17</sup> I identified single case agreement claims in United's Claims Data based on the following reason codes: "80" (description: *THE PROVIDER OF THIS SERVICE IS OUT-OF-NETWORK. WE HAVE RECEIVED MORE INFORMATION AND REPROCESSED THIS CLAIM. BASED ON A NEGOTIATED AGREEMENT WITH DATA ISIGHT THE PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE. THE DISCOUNT SHOWN IS YOUR SAVINGS AND IS NOT INCLUDED IN THE AMOUNT YOU OWE.*); "LI" (description: *THIS FACILITY, PHYSICIAN OR HEALTH CARE PROVIDER IS OUT-OF-NETWORK. BASED ON AN AGREEMENT WITH MULTIPLAN, THE PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE. THE DISCOUNT SHOWN IS YOUR SAVINGS AND IS NOT INCLUDED IN THE AMOUNT YOU OWE.*)

<sup>18</sup> I identified claims where the commercial payor is not the primary payor in United's Claims Data based on the following reason codes: "G7" (description: *YOU HAVE MEDICARE AS YOUR PRIMARY INSURANCE. YOUR BENEFIT FOR THIS SERVICE WAS DETERMINED BY USING THE AMOUNT APPROVED BY MEDICARE. MEDICARE PAYS FIRST AND YOUR PLAN PROCESSES THE CLAIM AFTER MEDICARE.*); "39" (description: *Payment for this service is denied. Our records show you have coverage with Medicare. Please send us a copy of the Medicare explanation of benefits (MEOB) that matches all services on this claim.*); "4C" (description: *You have Medicare as your primary insurance. Your benefit for this service was determined by using the amount approved by Medicare. Medicare pays first and your plan processes the claim after Medicare.*); "5S" (description: *This plan is your secondary plan, you have another insurance carrier as your primary plan. Benefits have been processed using your primary plans allowed amount. This is called coordination of benefits. The amount your primary plan allows is applied first, then we process your claim.*); "50" (description: *MEDICARE PART B IS YOUR PRIMARY CARRIER FOR THIS SERVICE. MEDICARE DID NOT PAY BECAUSE EITHER YOU ARE NOT ENROLLED IN PART B EVEN THOUGH YOU ARE ELIGIBLE OR YOU USED A PROVIDER WHO OPTED OUT OF OR DOES NOT ACCEPT MEDICARE.*); "51" (description: *You have Medicare as your primary payor. Your benefit for this service was determined by using the amount approved by Medicare. Medicare pays first and your plan processes the claim after Medicare.*); "AM" (description: *WE RETAIN THE SERVICES OF INGENIX TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE BASED ON A REVIEW BY INGENIX INDICATING MEDICAL PAYMENT/PERSONAL INJURY PROTECTION COVERAGE IS PRIMARY TO YOUR MEDICAL BENEFITS IF YOU HAVE ANY QUESTIONS*); "KR" (description: *YOUR PROVIDER MAY HAVE ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. WE HAVE COORDINATED BENEFITS WITH YOUR OTHER INSURANCE CARRIER UP TO THE AGREED AMOUNT.*); "SY" (description: *MEDICAID PAID THIS CLAIM BEFORE IT WAS CONSIDERED UNDER YOUR EMPLOYER HEALTH PLAN. OUR PAYMENT FOR THIS CLAIM WILL BE SENT DIRECTLY TO MEDICAID, NOT YOUR HEALTH CARE PROVIDER.*); "UV" (description: *PAYMENT FOR THIS SERVICE IS DENIED. OUR RECORDS SHOW YOU HAVE COVERAGE WITH ANOTHER CARRIER.*); "UW" (description: *THIS SERVICE WAS NOT APPROVED BY MEDICARE OR THERE IS NO PATIENT RESPONSIBILITY.*); "COB305" (description: *OUR RECORDS SHOW THE MEMBER HAS COVERAGE WITH MEDICARE.*); "COBD06" (description: *Processed these charges by coordinating the benefits received from your other insurance plan with the benefits available under this plan.*); "COB338" (description: *WE PROCESSED THIS SERVICE BY COORDINATING BENEFITS WITH MEDICARE.*).

<sup>19</sup> I identified non-final claim lines in United's Claims Data where the UNET Live *ServiceCurrentIndicator* field does not have a value of "Y" and/or where billed charges is zero.

<sup>20</sup> Complaint ¶ 8-12.

<sup>21</sup> I identified non-ERISA claims in United's Claims Data based on the following fields / values: UNET Archive – *ERISA\_IND* (value: "N" or "R"), UNET Live – *EriSaCode* (value: "NULL" or blank), UMR – *ERISA\_Status* (value: "CHRRCH" or "FEDG" or "GOVNF" or "NERSAO" or blank), Oxford – *ERISA\_IND* (value: "N").

<sup>22</sup> Complaint ¶ 47-48.

or other network facilities, where the services were provided on or after January 1, 2022.”<sup>23</sup> I therefore identified and excluded claims from United’s Claims Data subject to the federal NSA with dates of service starting January 1, 2022 (i.e., the effective date of the NSA) along with the following additional criteria.

1. Emergency Providers: I identified emergency claims submitted by emergency department providers based on information concerning the provider’s specialty. Only one of the three Defendant providers was an emergency services provider: InPhyNet Primary Care Physicians Southeast P.C.<sup>24</sup> I identified and excluded these claims from United’s Claims Data based on provider TIN.
  2. Emergency Room (“ER”) Indicator Claims: I also identified emergency claims and excluded these claims from United’s Claims Data based on the ER indicator field.<sup>25</sup>
  3. NSA Reason Codes: I identified and excluded claims from United’s Claims Data that were adjudicated under the Federal NSA based on the reason code field.<sup>26</sup>
  4. NSA Places of Service: I provisionally identified all claims with an inpatient hospital or outpatient hospital place of service as subject to the NSA, on the conservative assumption provided by Counsel that United had contracts with such facilities at all relevant times, and thus such services might be subject to the Federal NSA’s procedures. The place of service fields in United’s Claims Data were used to identify and exclude these claims from United’s Claims Data.<sup>27</sup> As explained further below, I then restored four claims to the disputed claims population relating to services that were performed at facilities which I understand were out-of-network at the time of service. Refer to the next section (**Section V.B**) of this declaration.
- xii. State NSA Claims: I also identified and excluded fully insured claims from United’s Claims Data that were adjudicated under state-specified law in Georgia similar to the NSA based on reason codes regardless of time period due to the fact that state-specified laws came into effect at different points in time than the Federal NSA.<sup>28</sup>

<sup>23</sup> Complaint ¶ 47; see also 26 U.S.C. § 9816(a)(1).

<sup>24</sup> Complaint ¶ 19.

<sup>25</sup> In this step, I used the UNET Live field *ER\_Indicator* with a value of “Y” to identify ER claims.

<sup>26</sup> I identified Federal NSA claims in United’s Claims Data based on the following reason codes: “NSA001” and “NSA002” (description: *YOU RECEIVED THIS SERVICE FROM AN OUT-OF-NETWORK PROVIDER AND THE CLAIM WAS PROCESSED USING YOUR NETWORK BENEFITS. THE PROVIDER MAY NOT BILL YOU MORE THAN THE COPAY, COINSURANCE, AND/OR DEDUCTIBLE AMOUNTS SHOWN.*); “NSA004” (description: *THIS CLAIM HAS BEEN REPROCESSED USING THE RATE NEGOTIATED WITH YOUR PROVIDER. THE PROVIDER MAY NOT BILL YOU FOR ANY AMOUNTS ABOVE YOUR COINSURANCE, COPAYMENT OR DEDUCTIBLE.*); “NSA007” (description: *THE CLAIM WAS SUBMITTED TO ARBITRATION, AND PAYMENT WAS ISSUED BASED ON THE ARBITRATOR’S DECISION.*).

<sup>27</sup> I identified inpatient hospital and outpatient hospital claims in United’s Claims Data using the following fields / values: UNET Live – *AMA\_POS* (value: “21” – Inpatient Hospital, “22” – Outpatient Hospital), UMR – *PlaceOfService* (value: “02” – Inpatient Services and Procedures, “04” – Outpatient Hospital, other than ER or Surgery or “05” – Outpatient Surgery), Oxford – *PLC\_OF\_SRVC* (value: “21” – Inpatient Hospital, “22” – Outpatient Hospital).

<sup>28</sup> I identified state NSA claims in United’s Claims Data based on the following reason codes: “CS” (description: *You received this service from a health care professional that is not in your plans network at a network facility. The claim was processed using your network benefits. Due to state law, the health care professional cannot bill you for any amount that is more than the deductible, copayment and coinsurance. You are an out-of-network health care professional and these services were rendered at a network facility. The claim was processed using the members network benefits.*); “CU” (description: *You received this service from a health care professional or facility that is not in your plans network. The claim was processed using your network benefits. Due to state law, the health care professional cannot bill you for any amount that is more than the copay, coinsurance, or deductible. This claim was processed using the members network benefits. Due to state law, you may not balance bill the member for any amount that is more than the applicable deductible, copay and coinsurance.*); “ENR006” and “ENR007” (description: *THIS CLAIM WAS PROCESSED USING THE MEMBER’S NETWORK BENEFITS. DUE TO STATE LAW, YOU CANNOT BILL THE PATIENT FOR ANY AMOUNT ABOVE THE COPAYMENT, COINSURANCE AND/OR DEDUCTIBLE.*); “OCM005” (description: *You do not participate in our network. The allowed amount for the services is intended to resolve this claim. The member is responsible only for the copayment, coinsurance and deductible amounts shown on this remittance advice statement. Please do not bill our member for other amounts.*).



- xiii. Discovery Correspondence Exclusions: I excluded claims that the parties agreed were no longer disputed.<sup>29</sup>

10. **Table 2** shows the claims excluded at each step of this process in a walkdown (i.e., each step is performed in order or in a hierarchy).

**Table 2: Disputed Claims Walkdown**

|                                                          | Claims        | Lines          | Charges             | Allowed             |
|----------------------------------------------------------|---------------|----------------|---------------------|---------------------|
| <b>United's Claims Data for Defendant Providers</b>      | <b>95,987</b> | <b>122,996</b> | <b>\$63,574,329</b> | <b>\$19,381,089</b> |
| <i>Less: Pre-Statute of Limitations</i>                  | 16,257        | 20,633         | \$11,182,909        | \$4,759,023         |
| <i>Less: Denied Claims</i>                               | 15,303        | 20,914         | \$14,168,717        | -\$715              |
| <i>Less: Rental Network Claims</i>                       | 12,959        | 16,085         | \$5,919,344         | \$4,933,439         |
| <i>Less: Participating Claims</i>                        | 24,230        | 32,176         | \$16,874,471        | \$5,980,382         |
| <i>Less: HMO Claims</i>                                  | 898           | 1,149          | \$584,758           | \$152,833           |
| <i>Less: Fully Insured Indemnity Claims</i>              | 3,526         | 3,660          | \$1,624,418         | \$92,284            |
| <i>Less: Single Case Agreement Claims</i>                | 5             | 26             | \$5,298             | \$2,126             |
| <i>Less: Commercial is Not Primary Claims</i>            | 7,611         | 8,217          | \$3,291,520         | \$248,945           |
| <i>Less: Non-Final Claim Lines</i>                       | 896           | 2,104          | \$4,157             | \$4,174             |
| <i>Less: Non-ERISA Claims</i>                            | 3,875         | 4,306          | \$2,149,258         | \$719,999           |
| <i>Less: Federal NSA 2022+ Emergency Providers</i>       | 471           | 673            | \$631,747           | \$187,155           |
| <i>Less: Federal NSA 2022+ Emergent Claims</i>           | 1             | 1              | \$1,015             | \$223               |
| <i>Less: Federal NSA 2022+ Reason Codes</i>              | 507           | 1,051          | \$190,308           | \$64,557            |
| <i>Less: Federal NSA 2022+ Places of Service</i>         | 2,807         | 3,234          | \$1,430,825         | \$450,252           |
| <i>Less: State NSA - Reason Codes</i>                    | 1,252         | 1,457          | \$752,982           | \$183,567           |
| <i>Less: Removed Claims per Discovery Correspondence</i> | 1             | 1              | \$701               | \$701               |
| <b>Disputed Claims</b>                                   | <b>6,289</b>  | <b>7,309</b>   | <b>\$4,761,902</b>  | <b>\$1,602,143</b>  |

11. Attached to this declaration as Exhibits 31 to 34 are true and correct copies of spreadsheets reflecting the disputed claims after United's Claims Data has been filtered as described above: Ex. 31: UHC0004828 (UNET), Ex. 32: UHC0004829 (UNET Archive), Ex. 33: UHC0004830 (Oxford), and Ex. 34: UHC0004831 (UMR).

12. The disputed claims identified above also include a number of claims for services provided by Defendants after January 1, 2022.

<sup>29</sup> April 1, 2025 Letter from William Pollak to Justin Fineberg re: Changes to Disputed Claims List and Responses to Deposition Demands.

## B. Additional Disputed Claims for Services Provided at Out-of-Network Facility Locations After 2021

13. I understand from Counsel that non-emergency services performed at out-of-network facilities are not subject to the NSA and therefore would be subject to this dispute. I received a facility claims dataset that included claims for the AdventHealth Redmond facility that I understand was out-of-network with United during the period December 4, 2023 through March 14, 2024.<sup>30</sup> I also reviewed a declaration of United's Director of Network Contracting: Valerie Leach<sup>31</sup> who confirmed that this facility was out-of-network with United during this period. I was asked by Counsel to review the facility claims data for this facility and time period and identify whether any of the Defendant provider professional claims were performed at this facility during this period. To do so, I matched these facility claims to the professional claims for Defendant providers during the facility's out-of-network period based on member name<sup>32</sup> and date of service.<sup>33</sup> As a result, I identified four additional non-emergency Defendant provider disputed claims performed at this out-of-network facility.<sup>34</sup> Attached to this declaration as Exhibits 35 to 36 are true and correct copies of spreadsheets reflecting these additional four disputed claims: Ex. 35: UHC0010442 (UNET) and Ex. 36: UHC0010443 (Oxford). **Table 3** summarizes the addition of the four additional disputed claims to the disputed claims population.

**Table 3: Addition of Four Additional Disputed Claims**

|                                                 | Claims       | Lines        | Charges            | Allowed            |
|-------------------------------------------------|--------------|--------------|--------------------|--------------------|
| <b>Disputed Claims before Additional Claims</b> | <b>6,289</b> | <b>7,309</b> | <b>\$4,761,902</b> | <b>\$1,602,143</b> |
| Additional Disputed Claims                      | 4            | 5            | \$10,760           | \$601              |
| <b>Total Disputed Claims</b>                    | <b>6,293</b> | <b>7,314</b> | <b>\$4,772,662</b> | <b>\$1,602,744</b> |

## C. Amounts Left Unpaid on Disputed Claims and Breakdown by Provider

14. I calculated the amounts in dispute (or "exposure") between TeamHealth and United (and the United benefit plans) based on the difference between billed charge amounts and the amounts allowed on such claims, according to United's Claims Data. I calculated exposure only for claims where the expected amount exceeds the allowed amount. **Table 4** shows a summary of disputed claims by Defendant provider with exposure at 100% charges.

<sup>30</sup> LGL\_TH\_FAC\_CLAIM\_SAMPLE\_FNL.

<sup>31</sup> Declaration of Valerie Leach, ¶ 6.

<sup>32</sup> Member name is reflected in the following fields: UNET professional claims data – *PatientFirstName* and *PatientLastName*; Oxford professional claims data – *MBR\_FST\_NM* and *MBR\_LST\_NM*; facility claims data – *MBR\_FST\_NM* and *MBR\_LST\_NM*.

<sup>33</sup> Date of service is reflected in the following fields: UNET professional claims data – *DOS\_Begin* and *DOS\_End*; Oxford professional claims data – *ERLY\_SRVC\_DT* and *LT\_SRVC\_DT*; facility claims data – *ERLY\_SRVC\_DT* and *LT\_SRVC\_DT*.

<sup>34</sup> These claims were identified in Exhibits A and B to the March 10, 2025 letter from Brian Boyle to Justin C. Fineberg re: *United Healthcare Services, Inc. v. Hospital Physician Services Southeast, P.C.*



**Table 4: Disputed Claims by Defendant Provider**

| Defendant Provider                               | Claims       | Charges            | Allowed            | Exposure at 100% Charges |
|--------------------------------------------------|--------------|--------------------|--------------------|--------------------------|
| Hospital Physician Services Southeast, P.C.      | 3,719        | \$1,416,925        | \$615,823          | \$801,644                |
| InPhyNet Primary Care Physicians Southeast, P.C. | 2,098        | \$2,361,655        | \$829,083          | \$1,535,738              |
| Redmond Anesthesia & Pain Treatment, P.C.        | 476          | \$994,082          | \$157,838          | \$853,387                |
| <b>Disputed Claims</b>                           | <b>6,293</b> | <b>\$4,772,662</b> | <b>\$1,602,744</b> | <b>\$3,190,768</b>       |

#### D. Identification of Plans Having Highest Counts of Disputed Claims for UNET

15. I was also asked by Counsel to identify the ten United benefit plans with the highest number of claims in the list of disputed claims for the UNET claim platform for the period July 8, 2019 through April 20, 2023. **Table 5** shows the top ten plans for UNET.<sup>35</sup>

**Table 5: UNET Plans with Greatest Disputed Claim Volume**

| Customer Group Name (Number)                        | Claims       | Charges            | Allowed            | Exposure at 100% Charges |
|-----------------------------------------------------|--------------|--------------------|--------------------|--------------------------|
| Delta Air Lines, Inc. (226310)                      | 650          | \$710,073          | \$225,154          | \$484,919                |
| Textron-Medical (714273)                            | 179          | \$70,590           | \$28,537           | \$42,053                 |
| FedEx Corporation (920923)                          | 177          | \$69,913           | \$24,807           | \$45,106                 |
| Insperity Holdings, Inc. (701648)                   | 126          | \$80,903           | \$17,434           | \$63,469                 |
| Love's Travel Stops & Country Stores, Inc. (905754) | 120          | \$59,133           | \$24,880           | \$34,253                 |
| Dollar Tree Management, Inc. (752495)               | 105          | \$62,157           | \$21,559           | \$40,599                 |
| Ryder System, Inc. (142290)                         | 101          | \$80,055           | \$27,640           | \$52,415                 |
| UnitedHealth Group (168504)                         | 89           | \$55,635           | \$20,459           | \$35,176                 |
| Duke Energy (729784)                                | 87           | \$32,547           | \$13,314           | \$19,233                 |
| Southwest Airlines Company (199409)                 | 86           | \$91,068           | \$33,542           | \$57,526                 |
| All Other Customers                                 | 4,084        | \$3,207,856        | \$1,056,197        | \$2,172,510              |
| <b>UNET (Live/Archive) Disputed Claims</b>          | <b>5,804</b> | <b>\$4,519,930</b> | <b>\$1,493,522</b> | <b>\$3,047,259</b>       |

<sup>35</sup> Customer numbers are identified based on the following fields: UNET Archive – CUST\_CONTR\_ID, UNET Live – SubscriberGroupNumber. Customer names are identified based on the following fields: UNET Archive – CUST\_CONTR\_NM, UNET Live – SubscriberGroupName.

16. I declare under the penalty of perjury under the laws of the state of California that the foregoing is true and correct. Executed April 11, 2025 at Los Angeles, CA.



Joao C. dos Santos

**JOAO DOS SANTOS, M.Sc.**

Senior Managing Director

Disputes &amp; Investigations; Economic &amp; Statistical Analysis; Data Analytics



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**EDUCATION**

M. Sc., Applied Economics,  
Rutgers University

B. S., Environmental and  
Business Economics, Rutgers  
University

G. H. Cook Scholar, G. H. Cook  
Honors Program, Rutgers  
University

**LANGUAGES**

Portuguese  
Spanish

**AFFILIATIONS**

American Statistical Association  
American Economics Association  
National Association of Certified  
Valuators and Analysts  
Association of Certified Fraud  
Examiners  
American Bar Association  
Big Brothers Big Sisters of LA  
Teach Democracy

Joao C. dos Santos is a Senior Managing Director in Ankura's Global Disputes and Economics practice with more than 25 years of experience in applying economic, financial, statistical and complex database methods to examine a variety of business issues, including dispute resolution, regulatory compliance, and strategic management. He has led over 100 engagements performing economic/financial analyses and valuations; developing statistical tests, sampling frameworks and econometric models; and conducting forensic data investigations.

Joao's experience in disputes and investigations includes: (i) evaluation of Rule 23 class certification requirements, (ii) assessment of materiality and loss causation, (iii) quantification of economic damages, and (iv) forensic investigations of alleged misrepresentations and misconduct. He has directed engagements involving a broad range of litigation and regulatory enforcement matters, including healthcare, class actions, complex commercial disputes, securities and white-collar fraud investigations. He has been qualified as an expert in economic damages, complex data analytics, and statistical methods. He has provided testimony in arbitration proceedings, state and federal courts, and has submitted expert reports to regulatory agencies.

Joao's experience in management consulting engagements includes the application of economic and finance theories and complex database analytics to issues ranging from demand and price analysis to customer relationship management and economic impact studies. He has led various large data analytics engagements to evaluate the potential impact of alternative business, taxation and regulatory scenarios in the U.S., Latin America and Asia.

## Experience Includes:

**Healthcare and Life Sciences** – Mr. dos Santos has led investigations related to Medicaid and Medicare false claims and fraud and abuse issues as well as issues related SEC reporting. He has also worked on a variety of complex disputes regarding contractual and claim adjudication issues. His work in this area often encompasses the application of complex data analytics, econometric modeling, and statistical sampling to evaluate questions related to reimbursement, pricing, eligibility, and cost reporting. Mr. dos Santos has also been retained by Life Sciences companies to assist with issues related to complex civil litigation and strategic management.

- *OON Claims Pricing* – In various payer-provider disputes regarding pricing of out-of-network anesthesiology, radiology and ER services, evaluated usual and customary rates for relevant market and service and calculated fair market, reasonable value for disputed claims. Work included economic analysis of relevant market, pricing and competition, review and analysis of electronic claims databases and benchmarking, and research of economic literature. Deliverables included expert report and testimony.
- *Claims Reimbursement* – In an arbitration proceeding between a payer and a provider of healthcare services, (i) conducted forensic review of claims data to examine consistency of adjudication process relative to contractual provisions; (ii) evaluated and responded to assertions of claimant's experts; and (iii) served as neutral statistical expert. Work included statistical sampling and extrapolation, complex database mining, development of claim pricing models.
- *Breach of Contract and Misrepresentation* – For a group of skilled nursing facilities (SNF) facing allegations of improper staffing, examined class-certification criteria and ascertainability of economic damages. Work included statistical analysis of SNF resident data, assessment of opposing expert's proposed analytical framework for determination of common impact and quantification of economic damages.
- *Coverage and Cost-Sharing* – For a healthcare payer facing allegations of denied access to and coverage for services mandated by the ACA, performed data analyses of large relational database of claims to (i) independently examine the adequacy of in-network providers across markets and over time, (ii) evaluate class certification criteria, including assessment of potential need for individualized inquiry, and (iii) quantify potential economic exposure.
- *Unpaid Interest* – For a managed care organization facing allegations of failure to pay interest on Medicaid claims, was retained to evaluate class-certification criteria and assess economic damages. Work included data analyses of structured claims data and documentation to determine whether a systematic approach can be applied to identify class and to calculated alleged owed interest. Deliverables included expert report and testimony.
- *Medicare False Claims* – In a qui tam healthcare fraud investigation, led statistical modeling and complex data analytics initiative to estimate contested fiscal intermediary adjustments and to evaluate DRG upcoding claims. Work included the construction and analysis of large cross-sectional database, specification of regression models, statistical tests and extrapolations.
- *Market Power and Pricing* – As part of a proposed merger, developed analytical model to estimate the potential anticompetitive impact from the transaction. Work included the analysis of market share and market power across different geographic regions and the review of potential price-fixing. Combined geo-referenced mapping software information with provider and patient data to calculate distances to relevant physician locations and test whether certain federal provisions were being met.

**Statistical Sampling and Econometric Analysis** – Mr. dos Santos has demonstrated experience in applying a broad range of statistical and econometric modeling methods to evaluate questions related to business strategy, compliance, and litigation. He has designed sampling plans and econometric models to create extrapolations and forecasts, as well as to test specific hypotheses. He has evaluated and provided independent opinions regarding the reliability of sampling plans and extrapolations.

- *Healthcare* – For various healthcare payers and providers, was retained as a statistical and data analytics expert to design sampling and extrapolation plans. Work included analysis of claims data, design and selection of statistical samples, review of claims, and extrapolation of results. Deliverables included drafting of expert reports and testimony.
- *Construction* – For an international construction company involved on a major capital project in Latin America, designed statistical sampling plan and evaluated results as part of a contract compliance analysis and cost investigation.
- *Government Contracts* – In various disputes involving government contracts, developed statistical and data analysis to support cost audits and forensic reviews of allowances. Work included review of contracts, design of statistical sampling frameworks, statistical sample selection, analysis and extrapolation of results.
- *Book Publishing* – In breach of contract dispute between a book publisher and a distributor, designed statistical plan to evaluate rate of counterfeiting across various business channels and markets. Work including sample size calculation, sample selection, analysis and extrapolation of results.
- *Pharmaceuticals* – In an intellectual property dispute between two U.S. pharmaceutical companies, analyzed numerous large-scale sales databases and statistical surveys to render expert opinions in an arbitration involving market share determination as part of a joint-licensing agreement for a patented pharmaceutical drug.
- *Financial Services* – For a financial institution facing a challenging document production request, developed statistical sampling framework to evaluate effectiveness of document review process and to estimate error rates and related risk from managed document review process.
- *Manufacturing* – For a manufacturer of computer hardware involved in a product liability dispute, developed statistical sampling and extrapolation plan to examine failure rates of computer hard-drives. Work included complex data analysis of manufacturing and product distribution data.
- *Financial Services* – For the officers of a company accused of perpetuating a scheme to defraud investors, conducted extensive analysis of Private Investments in Public Equities (PIPEs). Performed econometric analysis to measure the aspects of PIPE transactions that are material to investors, and their respective effects on subject company stock prices.
- *Event Ticket Resale* – For an event ticket resale company involved in a breach of contract dispute, queried and analyzed large historical databases of transaction and customer “click” data to evaluate customer activity patterns. Work included design of statistical sampling and extrapolation plan to validate reliability of data sources and to assess alleged error rates for certain commission payments.

**Class Action Litigation** – Mr. dos Santos is experienced at applying various data-driven techniques such as statistical sampling, big data analytics, econometric modeling, and survey research to evaluate a broad range of economic issues that can arise in class action cases, including the determination of common impact on a class-wide basis, proof of injury, analysis of intra-class conflict, and the feasibility of standard approaches to quantification of damages.

- *Securities* – For a healthcare services provider involved in a derivative securities fraud claim, developed event studies and multi-trader models to evaluate materiality and loss-causation of alleged misconduct, as well as to calculate range of potential economic damages. Deliverables included expert report and presentation to support mediation and settlement discussions.
- *Product Liability* – In a product liability class action dispute against a manufacturer of baby products, developed econometric models and statistical tests to evaluate class certification issues and to develop damages scenarios. Work product included presentation used in settlement negotiation.
- *Consumer* – For fertility clinic involved in class action dispute related to a failure in cryopreservation storage tanks, collected and analyzed data from various databases to assess class certification criteria and assess potential economic damages.
- *Consumer* – For an insurance company facing a class action dispute associated with allegations of violation of the Telephone Consumer Protection Act, built and analyzed large relational database of call records and other consumer information to evaluate commonality, typicality and ascertainability. Deliverables included demonstratives and documentation to support settlement negotiation, including estimation of potential economic damages.
- *Consumer* – For an electric utility involved in a consumer class action, evaluated Rule 23 class certification criteria, including representativeness of lead plaintiffs. Work included reconstruction and analysis of billing database spanning a period over 10 years and including more than a million consumer accounts. Deliverables included expert report. The court denied class certification.
- *Securities* – For the insurance carrier of a publicly-traded broker-dealer facing a Section 10(b) securities class action litigation related to insider trading allegations, estimated potential exposure, evaluated materiality and loss-causation, and performed econometric analysis of similar class action cases to estimate the likely dollar range of settlement. Deliverables resulted in a settlement approved by the defendant's insurance carrier.
- *Property Value Diminution* – For an oil company involved in a class action dispute related to MBTE ground water contamination, developed analytical methodologies to test and quantify the alleged property value diminution resulting from ground water contamination by an underground oil tank. Deliverables included presentation to support mediation discussions.
- *Toxic Tort* – In a class action dispute involving a chemical manufacturer, developed economic study to evaluate the claim of alleged property value diminution in rural West Virginia resulting from air emissions (Carbon Black particles). Work involved the development of a geo-referenced database tool and statistical models to estimate the impact on housing value from contamination and perceived health risk.

**Complex Commercial Litigation** – Mr. dos Santos is experienced at applying complex database analytics, economic, financial and statistical methodologies to evaluate questions related to materiality, loss causation, economic damages and lost profits, in association with a broad range of allegations including breach of contract, misrepresentations and misconduct, competition and intellectual property.

- *Breach of Contract and Competition* – For a beverage company facing charges of breach of contract and anticompetitive behavior, performed analysis of contracts, historical sales, and market conditions. Work included querying of complex databases, economic analyses of demand and price, and quantification of economic damages. Work product included expert report, deposition and trial testimony.
- *Breach of Contract* – For an online university involved in a breach of contract dispute, was retained as the testifying expert to render opinion related to loss causation and lost profits. Work involved forensic database review of transactions and contracts, financial and econometric modeling of the relationship between advertising spend and revenues.
- *International Arbitration* – In post-acquisition dispute involving allegations of misrepresentations and misconduct, directed forensic investigation of transactional, financial, customer relationship, and communication records to evaluate claims of improper revenue recognition, fraud, and FCPA violations. Work included complex data analytics, interviews, electronic document review, and estimation of purchase price adjustment.
- *Financial Fraud* – On behalf of the Department of Justice, conducted complex data analytics of large transactional databases designed to evaluate a target company's daily exposure to particular interest/exchange rate measures (LIBOR/FOREX). Deliverables included calculations of gains or losses resulting from alleged manipulation of specific interest/exchange rates and identification of domestic counterparties.
- *Misconduct and Negligence* – For a minority owner of an oil well in the Gulf of Mexico, quantified exposure to economic damages claims as well as fines and penalties resulting from an explosion at the well and subsequent oil spill. Deliverables included exposure analysis and assistance in arriving at a settlement that resulted in our client's indemnification from future claims stemming from the spill.
- *Bankruptcy* – On behalf of the bankruptcy trustee of a petroleum distributor, directed reconstruction and analysis of historical transactional database of derivative trades to evaluate allegations of management misconduct. Work included financial analysis of futures trading portfolio to examine the relationship between physical stock, trading positions, and prices.
- *Antitrust* – In a dispute involving the sale and distribution of luxury watches, developed econometric models and performed financial analyses to evaluate loss causation and to quantify lost profits related to price discrimination claims under the Robinson-Patman Act. Work included the estimation of elasticities of selected advertising marketing programs, market share analysis, and determination of relevant geographic and product markets.
- *Trade Secrets* – For a hedge fund manager involved in a trade secrets claim, performed complex data analysis and forensic investigation to evaluate claim of misappropriation of proprietary trading algorithms.



**Labor and Employment** – In labor and employment disputes, Joao is experienced at applying economic and finance methods, big analytics, statistical sampling and hypothesis tests to evaluate the merits of employee claims and to examine certification criteria of purported class members. He has analyzed drivers of promotion, wages, or employment, and quantified economic damages in both single plaintiff and class action matters.

- *Retaliation and Wrongful Termination* – As part of a post-acquisition dispute, evaluated allegations of wrongful termination associated with the suspension and dismissal of the managing director of the acquired firm. Work included analysis of employment and salary history, quantification of potential economic damages, and evaluation of plaintiff's expert opinions.
- *Wrongful Termination and Discrimination* – In a single-plaintiff dispute regarding alleged racial discrimination and wrongful termination, conducted forensic, financial and statistical analyses to evaluate drivers of promotion and wages; and estimated economic damages.
- *Breach of Contract and Wrongful Termination* – For a defense contractor involved in a breach of contract and wrongful termination dispute, conducted forensic review of communications, HR and payroll records, and financial statements to evaluate questions regarding drivers of promotion and wages and to assess alleged economic damages.
- *Meal and Break Violation* – For a construction firm facing claims related to unpaid wages, developed complex relational database of time-keeping, payroll, and geo-referenced employee data. Designed database algorithms and statistical analyses to evaluate class certification criteria and to estimate potential economic damages. Motion for class certification was denied.
- *Misclassification* – For a retailer involved in a labor and employment class action dispute, developed stratified statistical sampling and extrapolation methodology to sample exempt employees; and designed time and motion study to evaluate types of tasks performed by distinct groups of employees and their required time to completion.
- *Gender Discrimination* – In a labor and employment class action dispute involving a temporary employment agency, performed statistical and database analyses to evaluate alleged wage disparity claim. Work included the development of statistical and database models and drafting of expert report.
- *RIF Analysis* – For a national security laboratory, performed an adverse impact analysis on gender, race and age in connection with a scheduled reduction in force (RIF). Work included review of statistical analysis conducted by an EEOC expert.
- *Regulatory Compliance Study* – For a healthcare agency, developed a time and motion study to evaluate the allocation and classification of time of personnel across various operational processes and healthcare programs. Work included the design of an automated database tool to collect and summarize findings. Deliverables included statistical extrapolation of results, drafting of reports and presentation of results.



**Securities Litigation, Regulatory Enforcement, and White-Collar Fraud** – Mr. dos Santos has extensive experience in conducting econometric, statistical and financial analyses (e.g., event studies, market efficiency tests, trader models, market impact analyses, option pricing, financial modeling, stochastic simulations, and valuations) to examine materiality and loss causation of selected events, and to evaluate economic damages. Furthermore, he is experienced in analyzing trading databases to test patterns and allegations related to insider trading, market manipulation, and trade allocation.

- *Technology* – On behalf of the former general counsel for a software company facing civil and criminal securities-related charges, evaluated the materiality of alleged misrepresentations. Analyses included event studies of stock price reactions to announcements of cash- and non-cash-related surprises and examination of the amount of analyst coverage dedicated to selected topics. Results included complete exoneration of both civil and criminal charges for the defendant.
- *Alternative Investments* – For a large hedge fund involved in a joint investigation by the SEC, NFA and CFTC, conducted database, financial and statistical analyses of historical trading activities and patterns. Work included (i) independent review and forensic testing of historical trading databases for various asset classes; (ii) calculation and comparison of trading costs and execution performance metrics against market benchmarks; and (iii) assessment of reasonableness of selected fund expenses and commissions.
- *Financial Services* – On behalf of the Department of Justice, reconstructed a brokerage's order and trading databases to analyze claims that investors were defrauded by improper trade mark ups and insider trading. Work included identification of improper trade mark ups and falsified records. Deliverables included reports matching transcripts of electronic chats and phone calls with the corresponding order and trading activity to tie conversations to trading losses.
- *Financial Services* – For a financial institution serving as a bond trustee involved in a SEC investigation, reviewed opposing expert's calculations and opinions set forth to object a receiver's motion for approval of settlement amounts. Work involved development of Monte Carlo simulation models to estimate range of economic losses.
- *Financial Services* – For an investment firm involved in a FINRA investigation, conducted forensic review of selected trades and developed financial models to evaluate market impact and transaction costs associated with large volume trade orders. Work included preparation of presentation to support FINRA arbitration and settlement discussions.
- *Financial Fraud* – On behalf of the Department of Justice, conducted complex data analytics of large transactional databases designed to evaluate a target company's daily exposure to particular interest/exchange rate measures (LIBOR/FOREX). Deliverables included calculations of gains or losses resulting from alleged manipulation of specific interest/exchange rates and identification of domestic counterparties.
- *Pharmaceuticals* – In a bankruptcy matter involving a pharmaceutical company, examined the efficiency of the market for a lightly-traded stock and approximated the value of FDA approval. Analyses included event studies to isolate and quantify the effect of particular disclosures, correlation and regression analyses to examine market efficiency, and trader models to estimate the number of shares affected by alleged misrepresentations.

**Music, Sports & Entertainment** – Mr. dos Santos has directed various strategic management and privileged consulting engagements involving the music, sports and entertaining industries, including economic impact analyses, contract compliance reviews, valuations, litigation support, and forensic investigations.

- *Royalty Dispute* – For a class action dispute between a music streaming service and song publishers and writers, conducted economic analyses, financial modeling and valuations to quantify unpaid mechanical royalties. Deliverables include a declaration in support of class settlement.
- *Contract Compliance Reviews* – For various music, sports, and entertainment companies, led contract compliance audits and assessments of potential licensing fees dues. Work included review of contractual terms and analysis of various allocation methodologies used over time under various contracts.
- *Breach of Contract* – In a breach of contract dispute regarding the production of a portfolio of film productions, conducted statistical and financial analyses to evaluate the merit of allegations regarding expected financial performance and economic losses.
- *IP Dispute* – For a major entertainment company involved in a trademark ownership rights dispute, conducted complex data analytics and financial analyses of sales and distribution data related merchandising, DVDs, movies and other related materials to assess potential economic exposure.
- *IP Piracy* – For an entertainment company, directed economic study to quantify the financial impact from the purchase of pirated hard copies and illegal downloads of filmed entertainment product. Deliverables included the development of econometric and financial models to estimate lost revenues along various stages of the value chain.
- *Labor & Employment* – For an executive of a major music company contemplating the renewal of a five-year contract, provided valuations related to the stock-based portion of the compensation package. Work product supported negotiation of a multi-million dollar buyout of selected incentive payments.
- *Sales Forecasting* – For a large entertainment company, headed project to forecast sales return reserve levels of returned products. Work included review of reserve allocation models, distribution channel operations, and the development of statistical models to forecast returns.
- *Securities* – For a gaming industry company facing claims asserted under Sections 11, 12(a)(2) and 15 of the Securities Act of 1933, conducted financial analysis and modeling of traceable IPO shares to evaluate loss-causation and to estimate potential economic damages.

### Strategic Consulting, Economic and Financial Studies

- *Regional Economic Impact Study* – For a large U.S. parks and resorts company, conducted economic impact analyses to estimate the potential incremental economic, fiscal, and qualitative social impacts of a proposed expansion of its theme parks in the U.S. and China. Work included the development of input-output macro-economic models to quantify the direct, indirect, and induced economic impacts on selected economic areas resulting from potential investment scenarios. Deliverables included drafting of report and presentation to C-suite officers.
- *Economic Impact Analysis of State and Local Taxation* – For a healthcare company, studied the economic impact and financial risk exposure related to a potential change in state and local tax classification. Work included review of applicable tax rates, development of economic forecasts and simulations.
- *Economic Study and Policy Analysis* – For the U.S. Chamber Institute for Legal Reform, conducted empirical research on the gains and losses that are implied when investors sell or buy securities at what are purported to be artificially inflated prices because of alleged fraud. Work included the development of econometric models and statistical tests, as well as drafting of a white paper.
- *Demand/Price Analysis and Lifecycle Management* – For various U.S. pharmaceutical companies, directed empirical studies to render strategic recommendations on product pricing, marketing and lifecycle management. Work included supervision of primary market research, econometric modeling and financial simulations of product price and market share evolution, review of net present value of alternative strategic options.
- *Strategic Marketing and Customer Relationship Management* – For a major Hong Kong conglomerate, analyzed marketing and operational synergies across subsidiaries and developed recommendations for joint marketing campaigns. Developed statistical and neural-network models to identify marketing opportunities and simulate alternative business scenarios. Developed market research methodology, survey questions, and analyzed survey results. Assessed IT requirements and developed roadmap for group-wide data mining strategy.
- *Mergers and Acquisitions* – For a Native American tribe, performed valuations and created scenario analysis to examine the tax benefits stemming from the potential repurchase of a mine. Work product included discounted cash flow analysis and consultation through due diligence and price negotiations and resulted in a purchase at a favorable price.
- *Database Application Design* – For the Center of Medicare and Medicaid Services (CMS), developed operational strategy to streamline the HCPCS application process. Deliverables included recommendations for process improvements and the development of an automated web-application for processing, managing and improving communication between various stakeholders.
- *Market Share Analysis and Operational Improvement* – For a South American division of leading U.S. snack manufacturer, studied portfolio rationalization opportunities and quantified gains from increased distribution of core SKUs. Conducted market-share analysis and forecasting. Headed task force meetings to assess key operational requirements. Identified opportunities for re-structuring and outsourcing.

### **Presentations and Workshops**

- *"Virtual Trials, Depositions and Hearings in the Insurance Coverage Arena and Beyond,"* presented at ABA's Virtual Insurance Coverage Litigation Committee CLE Seminar, March 2021.
- *"Claims Session: The Claims Settlement Process,"* presented at Advisen's Transaction Insurance Insights Conference, NY Law School, NY, NY, February 2019.
- *"Ten Tips to Develop your Expert Witness Expertise,"* presented at ABA's Corporate Counsel Seminar, La Quinta, CA, February 2018.
- *"Fraud and Forensics Panel,"* presented at University of California Irvine's in UCI's Master of Public Accounting Professional Development Seminar, Irvine, CA, November 2017.
- *"Comparison of Labor Executive Orders Between Trump and Obama Administrations,"* presented at the WOOPS 2017 – Strategizing for Dealing with the Government Under the New Administration Conference, Marina Del Rey, CA, September 2017.
- *"Forensic Accounting in Compliance,"* presented at ACA's Annual Compliance Conference, Scottsdale, AZ, September 2011.
- *"Analysis of the Wealth Effects of Shareholder Proposals,"* presented at the Center for Capital Markets' meeting on Shareholder Rights, the 2008 Proxy Season, and the Impact of Shareholder Activism, U.S. Chamber of Commerce, Washington, DC, July 2008.
- *"Class Action Securities Litigation: Review of Recent Developments, Calculation of Damages, and Settlement Estimation,"* presented at the Gallagher Management Liability Niche Annual Conference, Chicago, IL, December 2006.

### **Publications and Papers**

- dos Santos, Joao, et al. *"Classwide Calculations May Get Price Premium Damages Wrong,"* Law360, August 2024.
- dos Santos. *"Assessing the Impact of the COVID-19 Pandemic on the Reps and Warranties Market,"* Ankura's Perspectives News Letters, April 2020.
- dos Santos and Vranca. *"Blockchain Technology: Emerging Trends in Litigation and Regulatory Enforcement,"* ABA Section of Litigation Expert Witness E-Newsletter, May 2018.
- dos Santos. *"Dial up Analytics: Using Forensic Techniques to Evaluate Class Certification in TPCA Class Actions,"* Forensic Focus, June 2015.
- dos Santos, et al. *"Quantitative Risk Analysis Adds Certainty to the Uncertain Litigation Environment,"* RKCO Advisor, May 2013.
- dos Santos and Song. *"Analysis of the Wealth Effects of Shareholder Proposals – Volumes I & II,"* White Paper, Commissioned by the U.S. Chamber of Commerce, June 2009.
- dos Santos, Joao. *"Managing Urbanization in the Southern Coastal Plain Region of New Jersey: Integrating Landscape Ecology and Economics,"* Master's Thesis, Rutgers University, New Brunswick, NJ, October 1998.

**Recent Expert Testimony, Declarations and Affidavits**

- Corpus Christi Medical Center, et al v. Aetna Network Services LLC., et al. American Arbitration Association. Case No. 01-23-0003-0299
- Bradford Emergency Group, LLC, et al v Blue Cross and Blue Shield of Florida, Inc. D/B/A Florida Blue and Health Options, Inc. In The Circuit Court of the 17th Judicial Circuit in and for Broward County, Florida. Case No. CACE-21-016779
- Spotlight Ticket Management, Inc. v. StubHub Inc. Superior Court of California for the County of Los Angeles. Case No. 20VECV00691
- David Swartz, et al v. Dave's Killer Bread, Inc. and Flower Foods, Inc. United States District Court Northern California. Case No. 4:21-cv-10053-YGR
- Antonio Mckinney, et al v. Corsair Gaming, Inc. United States District Court Northern District of California. Case No. 3:22-cv-00312-CRB
- Gulf to Bay Anesthesiology Associates, LLC v. United Healthcare of Florida, Inc., United Healthcare Insurance Co., and UMR, Inc. Circuit Court for the 13th Judicial Court in and for Hillsborough Country, Florida. Case No. 20-CA-008606
- Lenny & Larry's, LLC v. A&B Ingredients, Inc. Superior Court of the State of California County of Los Angeles. Case No. 19STCV37687
- Judicial Council Coordinated Proceedings: In Re Rechnitz Nursing Facilities. Superior Court of the State of California County of Los Angeles. Case No. JCCP4988 [Lead Case No. BC711982]
- Health Services Network Hospitals, Inc. v. Humana Insurance Company and Humana Health Plan, Inc., Humana Government Business, Inc. American Health Law Association Alternative Dispute Resolution. Case No. AHLA Case No. 7030
- Frederick Scott Levine, et al v. Volvo Cars USA, LLC. In the United States Court for the District of New Jersey. Case No. 2:18-CV-03760
- Paseo Condominiums Fort Myers, Florida and Paseo Condominium Association, Inc. v. Stock Development LLC, et al. Lee County, Florida - Twentieth Circuit Court. Case No. 2018-CA-4742
- Sutter Health, et al v. Health Plan of San Joaquin. JAMS Arbitration. Case No. 1130009155
- Thomas Ellsworth v. American Greetings Corporation, In the Court of Common Pleas Civil Division Cuyahoga County, Ohio. Case No. 19-923088
- Florida Emergency Physicians Kang & Associates, M.D., Inc. et al v. Celtic Insurance Company, D/B/A Ambetter from Sunshine Health. In the Circuit Court for The Seventeenth Judicial Circuit in and for Broward County, Florida. Case No. CACE 19013026 (07)
- Gulf to Bay Anesthesiology Associates, LLC v. United Healthcare of Florida, Inc. and United Healthcare Insurance Co., Circuit Court for the 13th Judicial Court in and for Hillsborough Country, Florida. Case 8:18-cv-00233-EAK-AAS

**Recent Expert Testimony, Declarations and Affidavits (Cont'd)**

- Adventist Health System / Sunbelt Inc. v. Humana Medical Plan, Inc., et al. American Arbitration Association. Case No. 01-19-0002-6864
- County of Nassau and County of Suffolk v. Purdue Pharma L.P., et al. Supreme Court of the State of New York County of Suffolk. Index Nos. 400008/2017 (Nassau), 400001/2017 (Suffolk)
- The Ministry of Education, et al v. Carter Holt Harvey Ltd., et al. In the High Court of New Zealand, Auckland Registry. CIV-2013-404-1899
- Baptist Hospital of Miami, Inc., et al v. Medica Healthcare Plans, Inc. Miami-Dade County Circuit Court, Florida. Case No. 1:18-CV-25460-RS
- Shaghal, Ltd. V. Children's Network, LLC dba Sprout, JAMS Arbitration. Case No. 1210035113
- iTi, Inc. v. ZICO beverages, LLC, American Arbitration Association. Case No. 07-17-0007-5839
- Rachel Condry, et al v. UnitedHealth Group, Inc, et al. U.S. District Court, Northern District of California. Case No. 3:17-cv-00183-VC
- Crosswinds Rehab Inc., LLC, et al v. American Eldercare, Inc., et al. Circuit Court in the 11<sup>th</sup> Judicial Circuit in and for Miami-Dade County, Florida. Case No. 17-023840-CA-44
- Melissa Ferrick, et al v. Spotify USA Inc, et al. U.S. District Court, Southern District of New York. Case No. 1:16-cv-08412 (AJN)
- Sutter Health, et al v. Anthem Blue Cross Life and Health Insurance Company. JAMS Arbitration. Reference No. 1130006494
- Orologio of Short Hills, Inc. v. the Swatch Group (U.S.), Inc. U.S. District Court, District New Jersey. Case No. 11-6854 (SDW)
- Michael Colaco v. Cavotec S.A., Orange County Superior Court in California. Case No. 30-2012-00601735
- PSC Industrial Outsourcing LP v. Leslie Jackson, Superior Court of the State of California County of Los Angeles. Case No. BC597598
- Kelleher v. Kelleher, Dean, and Wells. U.S. District Court, Northern District of California. Case No. CV135450-MEJ
- Securities and Exchange Commission v. Medical Capital Holdings, Inc. et al. U.S. District Court – Central District California. Case No. SACV 09-818 DOC
- State of Arizona v. L. Spear, LLC. Superior Court of the State of Arizona – Cochise County. Case No. CV200900828
- Jose Moreno et al. v. J. Redfern, Inc. et al. Alameda County Superior Court. Case No. RG08375539

# Exhibit 31

(Filed Under Seal)

# Exhibit 32

(Filed Under Seal)



# Exhibit 33

(Filed Under Seal)

# Exhibit 34

(Filed Under Seal)

# Exhibit 35

(Filed Under Seal)

# Exhibit 36

(Filed Under Seal)

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,  
INC.; UNITED HEALTHCARE  
INSURANCE COMPANY; AND UMR,  
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES  
SOUTHEAST, P.C.; INPHYNET  
PRIMARY CARE PHYSICIANS  
SOUTHEAST, P.C.; AND REDMOND  
ANESTHESIA & PAIN TREATMENT,  
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

**DECLARATION OF ERIKA MAYERS IN SUPPORT OF PLAINTIFFS’  
MOTION FOR SUMMARY JUDGMENT**

I, Erika Mayers, state and declare as follows:

1. My current title is Senior Clinical Data Analyst on the UM Product team. Prior to January 2025, I was a Senior Reporting Analyst in UMR’s Internal Operational Reporting Department since UMR was formed in 2007.

2. Based on my experience as a Senior Clinical Data Analyst and my prior position as a Senior Reporting Analyst, I am generally familiar with records related to the submission and administration of benefit claims, and the underlying policies

issued and/or plans administered by Plaintiff UMR, Inc. (“UMR”). UMR is a Third Party Administrator (“TPA”), meaning all of UMR’s clients are self-funded. I am familiar with the manner in which business records of UMR are maintained. I have access to records related to the submission and administration of benefit claims, and the underlying plans administered by UMR. As part of my duties, I access and generate reports generated by UMR’s commercial electronic claims systems.

3. I base my statements contained herein upon my personal knowledge and from information obtained from various sources, including UMR’s corporate and business records and business documents contemporaneously maintained by UMR in the regular and ordinary course of business.

4. UMR’s Claims Payment System (“CPS”) system stores data relating to claims submitted to and administered by UMR. All of the claims data in UMR’s CPS data system are for self-funded customers—UMR does not have any fully-insured business. UMR maintains this claims-specific data on the CPS data system in the regular course of its business. The CPS system was maintained by UMR in the regular course of its business; and it was a regular business activity of UMR to maintain such records.

5. In connection with this litigation, I accessed UMR’s CPS and generated reports reflecting health benefit claims submitted to UMR by TeamHealth providers between 2018 through 2024.

6. Exhibit 34 to this Declaration is a true and correct spreadsheet bates stamped “UHC0004831” containing information relating to benefit claims submitted to UMR by TeamHealth entities. The data reflected in this spreadsheet was collected from UMR’s CPS data system and various filters were applied in excel. The data reflected in this spreadsheet was created at or near the time of the underlying claims by a person having regular knowledge of those matters; were maintained by UMR in the regular course of its business; and were made as a regular business activity of UMR to maintain such records.

7. Based on my experience, the fields in Exhibit 34, bates stamped UHC0004831, have the following meaning:

a. The column titled “ERISA\_Status” with a value of “ERISA” indicates that the claim was paid and processed pursuant to a health plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (“ERISA”).

b. The column titled “ProviderTIN” reflects the tax identification number of the provider entity that submitted the claim.

c. The column titled “ClaimNumber” reflects the unique claim number assigned to each claim.

d. The column titled “ProcedureCode” reflects the Current Procedural Terminology (“CPT”) code submitted by the TeamHealth

Defendants to describe the services associated with each patient's claim.

e. The column titled "ServiceDate" reflects the date the TeamHealth Defendants provided the services associated with each patient's claim.

f. The column titled "EndDate" reflects the final date the TeamHealth Defendants provided the services associated with each patient's claim.

g. The column titled "PaidDate" reflects the date UMR paid funds to the TeamHealth Defendants for the services associated with each patient's claim.

h. The column titled "ChargeAmount" reflects the full billed charges that the TeamHealth Defendants sought for the services associated with each patient's claim.

i. The column titled "AllowedAmount" reflects the amount UMR calculated as eligible for coverage based on the health plan sponsor's selected benefits for the services associated with each patient's claim. The Allowed Amount column includes amounts owed by UMR as well as amounts owed by the patient including copays, deductibles, and coinsurance per the terms of the health plan.



j. The column titled “TotalPaidAmount” reflects the payments UMR made to the providers.

k. The column titled “DeductibleAmount” reflects the portion of the allowed amount attributable to the member’s deductible per the terms of the health plan.

l. The column titled “Copay” reflects the portion of the allowed amount attributable to the member’s co-pay per the terms of the health plan.

m. The column titled “PatientAccountNbr” reflects the number assigned to each patient in the TeamHealth Defendants’ billing system.

n. The column titled “ClaimantName” reflects the first and last name of the patient associated with the claim.

o. The column titled “ClaimantFirstName” reflects the patient’s first name associated with the claim.

p. The column titled “ClaimantLastName” reflects the patient’s last name associated with the claim.

q. The column titled “GroupNumber” reflects the UMR health plan sponsor’s customer group number UMR uses to track customers associated each patient’s claim.

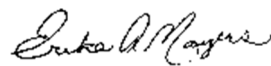
r. The column titled “Customer” reflects the UMR health plan sponsor’s customer name associated with each patient’s claim.

s. The column titled “NetworkInd” with a value of “P” within this column indicates that the claim was paid or administered under a provider network participation agreement.

t. The column titled “PlaceOfService” reflects the place of service (i.e., the setting in which the service was performed). The value of “02” indicates an inpatient hospital. The value of “04” indicates an outpatient hospital. The value of “05” indicates outpatient surgery.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 11th day of April, 2025 in Kentucky.



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Erika Mayers

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,  
INC.; UNITED HEALTHCARE  
INSURANCE COMPANY; AND UMR,  
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES  
SOUTHEAST, P.C.; INPHYNET  
PRIMARY CARE PHYSICIANS  
SOUTHEAST, P.C.; AND REDMOND  
ANESTHESIA & PAIN TREATMENT,  
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221f-JPB

**DECLARATION OF ROBERT BECK IN SUPPORT OF PLAINTIFFS’  
MOTION FOR SUMMARY JUDGMENT**

I, Robert Beck, state and declare as follows:

1. I have been a Senior Manager of Core Operations at United HealthCare Services, Inc. for approximately 3 years. I’ve been employed by United HealthCare Services, Inc. for approximately 27 years.

2. In my position as a Senior Manager, I am generally familiar with records related to the submission and administration of benefit claims, and the underlying policies issued and/or plans administered by Plaintiffs United HealthCare

Services, Inc. (“UHC”) and United Healthcare Insurance Company (collectively, “United”).

3. As part of my duties, I access reports generated from United’s commercial electronic claims systems, including the UNET platform (“UNET Platform”), the Oxford platform, and USP data platform. The UNET, Oxford, and USP data platforms store claims processing information, and are used to administer claims processed by plans associated with certain United affiliates. The UNET, Oxford, and USP data platforms are maintained, and information is generated and gathered therefrom in the regular and ordinary course of United’s business.

4. Based on my role, I am also generally familiar with United’s electronic claim system reports and data fields, including reports generated from other commercial electronic claims systems in addition to the UNET Platform, such as the COSMOS, UHOPS, and other platforms, that are used by certain United affiliates.

5. I base my statements contained herein upon my personal knowledge and from information obtained from various sources, including United’s corporate and business records and business documents contemporaneously maintained by United in the regular and ordinary course of business.

6. In connection with this litigation, I accessed United’s UNET, Oxford, and USP data platforms and generated reports reflecting health benefit claims submitted to United by TeamHealth providers between 2018 through 2024.

7. Exhibit 31, and 35 to this Declaration are true and correct spreadsheets bates stamped “UHC0004828” and “UHC0010442,” containing information relating to benefit claims submitted by TeamHealth providers to United. The data reflected in these spreadsheets was collected from United’s UNET data platform and various filters were applied in excel. The data reflected in this spreadsheet was created at or near the time of the underlying claims by a person having regular knowledge of those matters; were maintained by United in the regular course of its business; and were made as a regular business activity of United to maintain such records.

8. Based on my experience, the fields in Exhibit 31, bates stamped UHC0004828, and Exhibit 35, bates stamped UHC0010442 have the following meaning:

a. The column titled “ErisaCode” with a value of “E” indicates that the claim was paid and processed pursuant to a health plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (“ERISA”).

b. The column titled “ServicingProviderTIN” reflects the tax identification number of the provider entity that submitted the claim.

c. The column titled “ClaimID” reflects the unique claim number assigned to each claim in United’s UNET platform.

d. The column titled “ProcCode” reflects the Current Procedural Terminology (“CPT”) code submitted by the TeamHealth Defendants to describe the services associated with each patient’s claim.

e. The column titled “DOS\_Begin” reflects the first date the TeamHealth Defendants provided the services associated with each patient’s claim.

f. The column titled “DOS\_End” reflects the final date the TeamHealth Defendants provided the services associated with each patient’s claim.

g. The column titled “PaidDate” reflects the date United paid funds to the TeamHealth Defendants for the services associated with each patient’s claim.

h. The column titled “Billed\_Charges” reflects the full billed charges that the TeamHealth Defendants sought for the services associated with each patient’s claim.

i. The column titled “Allowed\_Amount” reflects the amount United calculated as eligible for coverage based on the health plan sponsor’s selected benefits for the services associated with each patient’s claim. The Allowed Amount column includes amounts owed

by United as well as amounts owed by the patient including copays, deductibles, and coinsurance per the terms of the health plan.

j. The column titled “Paid\_Amount” reflects the payments United made to providers.

k. The column titled “Deductible\_Amount” reflects the portion of the allowed amount attributable to the member’s deductible per the terms of the health plan.

l. The column titled “CoPay\_Amount” reflects the portion of the allowed amount attributable to the member’s co-pay per the terms of the health plan.

m. The column titled “Coinsurance\_Amount” reflects the portion of the allowed amount attributable to the member’s coinsurance per the terms of the health plan.

n. The column titled “PatAccNumber” reflects the number assigned to each patient in the TeamHealth Defendants’ billing system.

o. The column titled “PatientName” reflects the first and last name of the patient associated with the claim.

p. The column titled “PatientFirstName” reflects the United patient’s first name associated with the claim.

q. The column titled “PatientLastName” reflects the United patient’s last name associated with the claim.

r. The column titled “SubscriberGroupNumber” reflects the United health plan sponsor’s customer group number United uses to track customers associated each patient’s claim.

s. The column titled “SubscriberGroupName” reflects the United health plan sponsor’s customer name associated with each patient’s claim.

t. The column titled “Financial\_Arrangement” reflects the United health plan sponsor’s liability selection. Values of “ASO” within this column indicate that a plan is self-funded, meaning that United only administers the claims but is not financially responsible for the claims adjudicated under these plans. Values of “Fully Insured” within this column indicate that a plan is fully-insured, meaning that United is financially responsible, in full, for claims adjudicated under these plans. Values of “MP/MMP” within this column indicate a hybrid arrangement with elements of self-funded and fully-insured plans.

u. The column titled “ParStatus” with a value of “Y” within this column indicates that the claim was paid or administered under a provider network participation agreement.



v. The column titled “Plan\_Product” reflects the type of network product that the claim was paid or administered under. The value of “HMO” indicates an HMO product. The value of “IND” indicates an indemnity product.

w. The column titled “AMA\_POS” reflects the place of service (i.e., the setting in which the service was performed). The value of “21” indicates an inpatient hospital. The value of “22” indicates an outpatient hospital.

x. The column titled “ER\_Indicator” reflects whether the service was performed in the emergency room. The value of “Y” indicates the service was performed in the emergency room.

y. The column titled “ReasonCode” reflects the shorthand code used to document how the allowed amount for the claim was determined.

z. The column titled “ReasonCodeDescription” explains how the allowed amount for the claim was determined.

aa. The column titled “ServiceCurrentIndicator” reflects whether each row of claims data is current or has been superseded. A value of “Y” indicates that the line reflects a final adjudication of the claim.

9. Exhibit 32 to this Declaration is a true and correct spreadsheet bates stamped “UHC0004829” containing information relating to benefit claims submitted to United. The data reflected in this spreadsheet was collected from United’s UNET archive data system and various filters were applied in excel. The data reflected in this spreadsheet was created at or near the time of the underlying claims by a person having regular knowledge of those matters; was maintained by United in the regular course of its business; and was made as a regular business activity of United to maintain such records.

10. Based on my experience, the fields in Exhibit 32, bates stamped UHC0004829, have the following meaning:

a. The column titled “ERISA\_IND” with a value of “Y” indicates that the claim was paid and processed pursuant to a health plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (“ERISA”).

b. The column titled “ADJD\_PROV\_TIN” reflects the tax identification number of the provider entity that submitted the claim.

c. The column titled “CLM\_NUM” reflects the unique claim number assigned to each claim in United’s UNET platform.

d. The column titled “PROC\_CD” reflects the Current Procedural Terminology (“CPT”) code submitted by the TeamHealth

Defendants to describe the services associated with each patient's claim.

e. The column titled "ERLY\_SRVC\_DT" reflects the date the TeamHealth Defendants provided the services associated with each patient's claim.

f. The column titled "LT\_SRVC\_DT" reflects the final date the TeamHealth Defendants provided the services associated with each patient's claim.

g. The column titled "PAID\_DT" reflects the date United paid funds to the TeamHealth Defendants for the services associated with each patient's claim.

h. The column titled "CHRG\_AMT" reflects the full billed charges that the TeamHealth Defendants sought for the services associated with each patient's claim.

i. The column titled "ALLWD\_AMT" reflects the amount United calculated as eligible for coverage based on the health plan sponsor's selected benefits for the services associated with each patient's claim. The "ALLWD\_AMT" column includes amounts owed by United as well as amounts owed by the patient including copays, deductibles, and coinsurance per the terms of the health plan. The

column titled "PAID\_AMT" reflects the payments United made to providers.

j. The column titled "DED\_AMT" reflects the portion of the allowed amount attributable to the member's deductible per the terms of the health plan.

k. The column titled "COPAY\_AMT" reflects the portion of the allowed amount attributable to the member's co-pay per the terms of the health plan.

l. The column titled "COINS\_AMT" reflects the portion of the allowed amount attributable to the member's coinsurance per the terms of the health plan.

m. The column titled "PTNT\_ACCT\_NUM" reflects the number assigned to each patient in the TeamHealth Defendants' billing system.

n. The column titled "MBR\_FST\_NM" reflects the United patient's first name associated with the claim.

o. The column titled "MBR\_LST\_NM" reflects the United patient's last name associated with the claim.

p. The column titled “CUST\_CONTR\_ID” reflects the United health plan sponsor’s customer group number United uses to track customers associated each patient’s claim.

q. The column titled “CUST\_CONTR\_NM” reflects the United health plan sponsor’s customer name associated with each patient’s claim.

r. The column titled “FUND\_ARNG\_CD” reflects the United health plan sponsor’s liability selection. Values of “ASO” within this column indicate that a plan is self-funded, meaning that United only administers the claims but is not financially responsible for the claims adjudicated under these plans. Values of “FI” within this column indicate that a plan is self-funded, meaning that United only administers the claims but is not financially responsible for the claims adjudicated under these plans. Values of “FI” within this column indicate that a plan is fully-insured, meaning that United is financially responsible, in full, for claims adjudicated under these plans.

s. The column titled “NTWK\_IND” with a value of “I” within this column indicates that the claim was paid or administered under a provider network participation agreement.

t. The column titled “PRODUCT\_CODE” reflects the type of network product that the claim was paid or administered under. The value of “HMO” indicates an HMO product. The value of “IND” indicates an indemnity product.

u. The column titled “PLC\_OF\_SRVC” reflects the place of service (i.e., the setting in which the service was performed). The value of “21” indicates an inpatient hospital. The value of “22” indicates an outpatient hospital.

v. The column titled "SRC\_CLM\_RSN\_CD" reflects the shorthand code used to document how the allowed amount for the claim was determined.

w. The column titled "SRC\_CLM\_RSN\_DESC" explains how the allowed amount for the claim was determined.

11. Exhibits 33 and 36 to this Declaration are true and correct spreadsheets bates stamped “UHC0004830” and “UHC0010443” containing information relating to benefit claims submitted to United. The data reflected in this spreadsheet was collected from United’s Oxford and USP data platforms and various filters were applied in excel. The data in this spreadsheet was created at or near the time of the underlying claims by a person having regular knowledge of those matters; were

maintained by United in the regular course of its business; and were made as a regular business activity of United to maintain such records.

12. Based on my experience, the fields in Exhibits 33 and 36, UHC0004830 and UHC0010443 have the following meaning:

a. The column titled “ERISA\_IND” with a value of “Y” indicates that the claim was paid and processed pursuant to a health plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (“ERISA”).

b. The column titled "ADJD\_PROV\_TIN" reflects the tax identification number of the provider entity that submitted the claim.

c. The column titled “CLM\_NUM” reflects the unique claim number assigned to each claim in United’s Oxford and USP platforms.

d. The column titled “PROC\_CD” reflects the Current Procedural Terminology (“CPT”) code submitted by the TeamHealth Defendants to describe the services associated with each patient’s claim.

e. The column titled “ERLY\_SRVC\_DT” reflects the date the TeamHealth Defendants provided the services associated with each patient’s claim.

f. The column titled “PAID\_DT” reflects the date United paid funds to the TeamHealth Defendants for the services associated with each patient’s claim.

g. The column titled “CHRG\_AMT” reflects the full billed charges that the TeamHealth Defendants sought for the services associated with each patient’s claim.

h. The column titled “ALLWD\_AMT” reflects the amount United calculated as eligible for coverage based on the health plan sponsor’s selected benefits for the services associated with each patient’s claim. The “ALLWD\_AMT” column includes amounts owed by United as well as amounts owed by the patient including copays, deductibles, and coinsurance per the terms of the health plan.

i. The column titled "PAID\_AMT" reflects the payments United made to providers.

j. The column titled “DED\_AMT” reflects the portion of the allowed amount attributable to the member’s deductible per the terms of the health plan.

k. The column titled “COPAY\_AMT” reflects the portion of the allowed amount attributable to the member’s co-pay per the terms of the health plan.



l. The column titled “COINS\_AMT” reflects the portion of the allowed amount attributable to the member’s coinsurance per the terms of the health plan.

m. The column titled “PTNT\_ACCT\_NUM” reflects the number assigned to each patient in the TeamHealth Defendants’ billing system.

n. The column titled “MBR\_FST\_NM” reflects the United patient’s first name associated with the claim.

o. The column titled “MBR\_LST\_NM” reflects the United patient’s last name associated with the claim.

p. The column titled “CUST\_CONTR\_ID” reflects the United health plan sponsor’s customer group number United uses to track customers associated each patient’s claim.

q. The column titled “CUST\_CONTR\_NM” reflects the United health plan sponsor’s customer name associated with each patient’s claim.

r. The column titled “FUND\_ARNG\_CD” reflects the United health plan sponsor’s liability selection. Values of “ASO” within this column indicate that a plan is self-funded, meaning that United only administers the claims but is not financially responsible for

the claims adjudicated under these plans. Values of “FI” within this column indicate that a plan is fully-insured, meaning that United is financially responsible, in full, for claims adjudicated under these plans.

s. The column titled “NTWK\_IND” with a value of “I” within this column indicates that the claim was paid or administered under a provider network participation agreement.

t. The column titled “PRODUCT\_CODE” reflects the type of product that the claim was paid or administered under. The value of “HMO” indicates an HMO product. The value of “IND” indicates an indemnity product.

u. The column titled “PLC\_OF\_SRVC” reflects the place of service (i.e., the setting in which the service was performed). The value of “21” indicates an inpatient hospital. The value of “22” indicates an outpatient hospital.

v. The column titled “SRC\_CLM\_RSN\_CD” reflects the shorthand code used to document how the allowed amount for the claim was determined.

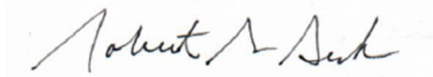
w. The column titled “SRC\_CLM\_RSN\_DESC” explains how the allowed amount for the claim was determined.

13. Based on my experience, the entries in the columns titled “ReasonCode” in Exhibits 31 and 35, the column titled “SRC\_CLM\_RSN\_CD” in Exhibit 32, and the column titled “SRC\_CLM\_RSN\_CD” in Exhibits 33 and 36, and have the following meanings:

- a. Codes “FV”; “IM”; “IT”; “IX”; “UE”; and “SSPMPL” reflect that the claim was paid using the Shared Savings Program wrap-rental network or fee negotiation out-of-network program.
- b. Codes “80”; and “LI” reflect that the claim was paid using a single-case negotiated fee agreement.
- c. Codes “G7”; “39”; “4C”; “5S”; “50”; “51”; “AM”; “KR”; “SY”; “UV”; “UW”; “COB305”; “COBD06”; and “COB338” reflect that the claim was paid on the understanding that Medicare, and not a commercial plan, was the primary payor.
- d. Codes “NSA001”; “NSA002”; “NSA004”; and “NSA007” reflect that the claim was paid on the understanding that the claim was subject to the Federal “No Surprises Act.”
- e. Codes “CS”; “CU”; “ENR006”; “ENR007”; and “OCM005” reflect that the claim was paid on the understanding that the claim was subject to state legislation addressing “surprise billing.”

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 11th day of April, 2025 in Phoenix, Arizona.

A handwritten signature in black ink, appearing to read "Robert Beck", is centered on the page. The signature is written in a cursive, flowing style.

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Robert Beck

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF GEORGIA**

UNITED HEALTHCARE SERVICES,  
INC.; UNITED HEALTHCARE  
INSURANCE COMPANY; AND UMR,  
INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES  
SOUTHEAST, P.C.; INPHYNET  
PRIMARY CARE PHYSICIANS  
SOUTHEAST, P.C.; AND REDMOND  
ANESTHESIA & PAIN TREATMENT,  
P.C.,

Defendants.

Civil Action No. 1:23-cv-05221-JPB

**DECLARATION OF VALERIE LEACH**

I, Valerie Leach, declare and state as follows:

1. I am employed by United HealthCare Services, Inc. (“UHS”) as a Director of Network Contracting for UHS and its affiliates (“United”).

2. I have been employed by UHS for approximately 27 years. In my role, I am familiar with United’s network contracts for physician groups and facilities in Georgia. I have personal knowledge of the following facts and, if called and sworn as a witness, could and would testify completely thereto.

3. United provides health insurance and serve as third-party claims administrators for certain health benefit plans in Georgia (“the United Benefit Plans” or the “Plans”).

4. Healthcare providers who have entered into contracts with United specifying mutually agreed reimbursement amounts for services provided to participants in United Benefit Plans are referred to by United as “network” or “participating” providers, and the contracts are referred to as “participating provider agreements.” Healthcare providers who do not have participating provider agreements with United subsidiaries governing reimbursement amounts for services provided to participants in United Benefit Plans are referred to as out-of-network or “non-participating” providers.

5. In my experience, hospitals and other facilities in Georgia occasionally terminate their participating provider agreements for various reasons, thus leaving United’s network of providers. Sometimes, United is able to quickly come to terms with the departing hospital or facility on a mutually acceptable participating provider agreement, such that the loss of the provider from the network is temporary. At other times, the loss of the provider from the network is extended.

6. For example, United did not have participating provider agreements in place with the following facilities in Georgia, during the periods specified:

- AdventHealth – Redmond E.R. from December 4, 2023 through March 14, 2024;
- Grady Memorial Hospital from October 1, 2016 through May 14, 2023;
- Children’s Healthcare of Atlanta, Hughes Spalding Hospital from December 8, 2016 through the present;
- Miller County Hospital from July 1, 2018 through the present.

As a result, during the periods specified, these healthcare facilities provided services as out-of-network providers.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 9<sup>th</sup> day of April, 2025 in North Carolina.



/s/

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Valerie Leach