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

UNITED'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

In attempting to avoid the conclusion that their threatened claims against United are preempted by ERISA, Defendants take a two-pronged approach.[1] Defendants' first gambit is to once again attempt to avoid a ruling by this Court on the merits of the preemption question. This Court has already ruled that discretionary abstention is not warranted and that it has Article III jurisdiction over this action. Defendants point to no new developments and no record evidence that calls either of those conclusions into question. Instead, they insist that this Court should decline to exercise the jurisdiction it has already twice concluded that it has based on an invented "established facts" requirement. Defendants are mistaken: the phrase that they have plucked out of context is not some independent test but merely describes the Article III requirement of a "case or controversy," which this Court has already correctly found satisfied in light of the ongoing and intractable dispute between the parties. And as Defendants' own fulsome briefing of the preemption question confirms, none of the ostensibly undeveloped facts plays any role in analyzing and deciding that dispute. Defendants' renewed efforts to avoid this Court's assessment of the preemption issue are thus wholly without merit.

As to the actual merits of the preemption issue, Defendants fare no better. As United's summary judgment motion has explained, ERISA's express

[1] This memorandum refers to all Plaintiffs as "United."

preemption provision, Section 514, squarely encompasses the claims that Defendants have threatened to press against United in Georgia, *viz.*, non-contractual state-law claims for reimbursement of Defendants' unilaterally set billed charges without regard to Plan terms (the "Threatened Claims"). Long-settled principles of ERISA preemption make clear that, because such claims are premised on the plan-forged relationship between United and plan participants and because the claims would interfere with core plan administration functions by requiring plans to provide specific benefits, they "relate to" ERISA and are therefore preempted. 29 U.S.C. § 1144(a). Defendants' chief response is that the Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020), upended those longstanding principles and broadly carved out from preemption any state law that affects plan costs. That contention gravely misconstrues *Rutledge*. Defendants' remaining arguments against preemption are likewise unavailing. For the reasons set forth in greater detail below and in United's summary judgment motion, this 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. Dkt. 54-3, Paradise Decl. ¶¶ 3-4. Defendants are physician

staffing companies owned by TeamHealth Holdings, Inc. that have provided services in Georgia to participants in various Plans. *See* Dkt. 44, Answer ¶¶ 42, 44. Defendants have threatened to assert the Threatened Claims against United—namely, non-contractual state-law claims seeking reimbursement of unilaterally set billed charges for non-emergency services delivered to Plan participants at out-of-network hospitals. *See* Dkt. 59-4 at 5-6; *see also* Mem. of Law in Support of United's Summary Judgment Motion ("United SJ Br."), Dkt. 54-1 at 4-5.

United initiated this action on November 13, 2023 and filed an Amended Complaint on January 26, 2024, seeking a declaration that ERISA preempts the Threatened Claims. Dkts. 1, 27. On February 8, 2024, Defendants filed a motion to dismiss, arguing (1) that the Court lacked subject-matter jurisdiction because United's allegations were too speculative to create a justiciable case or controversy and (2) that the Court should exercise its discretion under *Ameritas Variable Life Insurance Co. v. Roach*, 411 F.3d 1328 (11th Cir. 2005) (per curiam), to decline to entertain the action. Dkt. 29 at 11–22.

On August 16, 2024, this Court issued an order denying the motion to dismiss. Dkt. 43. The Court first held that it had subject-matter jurisdiction over the action, reasoning that there was "a substantial controversy between parties with adverse legal interests" that was "of sufficient immediacy" for Article III purposes. *Id.* at 8–12. The Court rejected Defendants' reliance on a declaration from

executive Kent Bristow regarding Defendants' present intent not to sue, explaining that it was insufficient to "extinguish[]" the threat of claims against United. *Id.* at 10. The Court next declined Defendants' invitation to exercise its discretion to abstain from deciding the action. *Id.* at 12–15. The Court laid out the *Ameritas* factors guiding the exercise of discretion and determined that abstention was not warranted because the declaratory judgment would "settle the controversy" and "clarify the legal relations at issue between the parties." *Id.* at 14. The Court accordingly denied the motion in full. *Id.* at 15.

Following discovery, United filed a summary judgment motion on April 11, 2025. Dkt. 54. Defendants subsequently filed another motion to dismiss, this time invoking a second Bristow Declaration that promised not to sue on pre-April 18, 2025 claims but offered no commitment as to later-arising claims. Dkt. 59 at 14.

On January 12, 2026, this Court issued a decision denying that motion as well. Dkt. 77. The Court rejected Defendants' argument that the risk of ongoing claims—namely, claims relating to non-emergency services delivered at out-of-network hospitals after April 18, 2025—was insufficiently likely to materialize, *id.* at 9–10, reasoning that such claims could arise "if a facility staffed by Defendants goes out-of-network," *id.* at 11. The omission of these future claims from the second Bristow Declaration underscored that the claims were not "as impossible as Defendants suggest." *Id.* The Court thus concluded that the case continued to

present a live case or controversy triggering subject-matter jurisdiction. *Id.* at 12.

ARGUMENT

I. Declaratory Relief Is Warranted

Defendants' renewed attempt to avoid this Court's consideration of the merits of the preemption question fares no better than its predecessors. Defendants simply repackage contentions this Court has already rejected in its prior rulings on jurisdiction and discretionary abstention—without pointing to any new developments that could justify departing from this Court's prior determinations.

A. Defendants' Arguments Are A Thinly Veiled Effort To Relitigate This Court's Prior Rulings

Defendants concede, as they must, that this Court has already "found that it holds Article III jurisdiction" over this action. Defendants' Mem. of Law In Support of Motion for Summary Judgment ("Def. SJ Br."), Dkt. 79-1 at 1; *see id.* at 6. This Court has likewise already rejected discretionary abstention under *Ameritas* as a basis to refrain from exercising jurisdiction over the action. *See* Dkt. 43 at 12–15. Undaunted, Defendants insist that there is a third avenue for this Court to decline to reach the merits of this case. According to Defendants, there is a "separate question" as to the propriety of "granting the relief United seeks" that requires this court to make a new determination as to whether there are sufficient "established facts" to allow for a declaratory judgment to issue. Def. SJ Br. 6 (quoting *Ashcroft v. Mattis*, 431 U.S. 171, 172 (1977) (per curiam)).

That is a fiction. *Ashcroft*'s "established facts" language originated in *Aetna Life Insurance Co. v. Haworth*, 300 U.S. 227 (1937), and was not intended to establish an independent requirement that every possible factual circumstance be firmly established in the record. Rather, the Court applied the phrase in confirming that the dispute before it was one "between parties who face each other in an adversary proceeding" while holding concrete "adverse positions," such that the dispute called not for "an advisory opinion upon a hypothetical basis, but for an adjudication of present right upon established facts." *Id.* at 239–42. Notably, the "established facts" the Court deemed significant were simply those facts necessary to crystallize a concrete legal dispute between the parties. *Id.* at 243. *Ashcroft* deployed the "established facts" language in precisely the same way, in furtherance of the Court's analysis of whether the case before it "present[ed] a live 'case or controversy.'" 431 U.S. at 172. Little wonder, then, that alongside *Haworth*, *Ashcroft* cited *Maryland Casualty Co. v. Pacific Coal & Oil Co*., 312 U.S. 270, 273 (1941)—the source of the canonical test for determining whether a Declaratory Judgment Act suit presents a constitutionally adequate "case or controversy." *See id.* ("[T]he question in each case is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment.").

Far from being a "separate question" presented to this Court for the first time, as Defendants contend (Def. SJ Br. 6), the inquiry as to whether this case calls for an "advisory opinion" or for "an adjudication of present right upon established facts" is thus the exact question this Court has already addressed in its two motion-to-dismiss rulings. *See* Dkt. 43 at 7–8 (reciting *Maryland Casualty* standard, holding that the case presents "a substantial controversy between parties with adverse legal interests" that "is of sufficient immediacy to warrant the issuance of a declaratory judgment," and rejecting "Defendants' argument that the controversy requirement is not satisfied"); Dkt. 77 at 12 (reaffirming that there remained a live case or controversy). Those prior rulings recognized that all of the facts necessary to crystallize the legal dispute between the parties into a concrete "case or controversy" are already established, leaving no "separate question" to be decided at this juncture as to the propriety of declaratory judgment relief.

Nor do Defendants succeed in generating a new "separate question" through their half-hearted invocation of discretionary abstention concepts. *See* Def. SJ Br. 10 n.6 (noting in a footnote the availability of discretionary abstention, but making no affirmative argument that such abstention is warranted under the *Ameritas* factors). Defendants' reluctance to actually advance an argument as to *Ameritas* discretion is understandable, since, as noted, this Court has already considered and rejected Defendants' arguments on that score. *See* Dkt. 43 at 12–15 (setting forth

Ameritas factors, analyzing Defendants' arguments in favor of discretionary abstention, and refusing to abstain).

In short, despite their efforts to frame their arguments against the issuance of relief as a novel and independent "separate question" distinct from the issues already considered and decided by this Court, Defendants' contentions in reality amount to a request for this Court to reconsider its prior rulings.

B. Defendants Offer No Basis For This Court To Depart From Its Prior Rulings

Defendants identify no new developments that undermine this Court's prior conclusion that this case presents a concrete and live controversy. Instead, they invoke the same arguments the Court has already rejected—that the second Bristow Declaration protects United from pre-April 18, 2025 claims and that there are currently no out-of-network facilities in Georgia staffed by Defendants. Def. SJ Br. 5–6. This Court has already explained that neither of those considerations negates Article III jurisdiction, and thus neither affords a basis to conclude that "a declaratory judgment cannot issue," as Defendants urge. *Id.* at 7.

Aside from failing to identify any salient new developments, Defendants also cannot show any error in this Court's prior decisions. Defendants fail to undermine the Court's well-founded determination that there remains a live possibility that a facility staffed by Defendants could go out-of-network with United. *See* Dkt. 77 at 10–12. Indeed, the evidence establishes that "hospitals and

other facilities in Georgia occasionally terminate their participating provider agreements [with United] for various reasons, thus leaving United's network of providers." Dkt. 54-44, Leach Decl. ¶¶ 5–6. Ample press releases and news coverage further confirm that it is not uncommon for facilities to leave the networks of United and other payers, with numerous such departures reported in recent months. *See, e.g.*, Ex. 2 to the Declaration of W. Pollak (reporting on ongoing failure in negotiations following departure of a North Carolina health system from United's network effective November 15, 2025); *id.* Ex. 3 (reporting on departure of Alabama hospital from United network in November 2025); *id.* Ex. 4 (reporting on temporary departure of Tennessee and Georgia facilities from Cigna's network in February 2026); *id.* Ex. 5 (reporting on departure of North Carolina hospitals from the Cigna network in December 2025); *id.* Ex. 6 (reporting on ongoing negotiations after Northeast Georgia Health System left United's network); *id.* Ex. 8 (similar); *see also id.* Ex. 9 (*Ne. Ga. Med. Ctr. Habersham, LLC v. United Healthcare of Ga., Inc.*, No. 2024cv000529 (Ga. Super. Ct., Hall Cnty. Aug. 1, 2025)) (deeming Georgia hospital an out-of-network provider after termination of facilities participation agreement by hospital acquisition); United SJ Br. 6–10 (marshalling ample undisputed facts that establish a live dispute).

Nor do Defendants succeed in identifying any unestablished "facts" that render the dispute too hypothetical to qualify as a concrete controversy. Contrary

to Defendants' assertion, and as this Court has recognized, the mere fact that "the claims upon which United seeks declaratory relief" do not yet "exist" does not render declaratory judgment unavailable. Def. SJ Br. 7; *See* Dkt. 43 at 8 (recognizing that the fact "that Defendants have not initiated suit against United regarding claims in Georgia" was not dispositive); *GTE Directories Publ'g Corp. v. Trimen Am., Inc.*, 67 F.3d 1563, 1569 (11th Cir. 1995) ("entertaining a declaratory judgment action on a somewhat hypothetical set of facts" is appropriate as long as there is a "practical likelihood that the contingencies will occur and that the controversy is a real one," in accordance with the prohibition on advisory opinions (quotation omitted; citing *Haworth*, 300 U.S. 227 at 240–41)).

What is more, each of the ostensibly "missing" facts invoked by Defendants, *see* Def. SJ Br. 7–9, is irrelevant for purpose of the preemption analysis—as Defendants themselves tacitly concede when, in Part II of their brief, they are able to fully articulate their position as to preemption without the benefit of any of the facts they deem lacking. Take, for instance, Defendants' assertion that "what types of medical services would be at issue … *i.e.*, hospitalist services vs. anesthesia services vs. obstetrical services etc." is currently unknown. *Id.* at 7. Defendants insist that this "distinction is important" because the underlying plans "may have different reimbursement protocols" for each type of service. *Id.* Yet Defendants overlook that this Court has no need to consider the particular "reimbursement

protocol" prescribed by the Plan to conclude that the Threatened Claims, by displacing any plan-defined reimbursement protocols and instead requiring payment in accordance with state law, interfere with plan administration and make reference to an ERISA plan in a manner that triggers preemption under Section 514. *See infra* Part II.A. For the same reason, it makes no difference to the preemption analysis whether a particular claim frames the recovery sought as "full billed charges" or a "reasonable" or "usual and customary" amount, Def. SJ Br. 7: what matters is that the claim seeks to supplant plan terms with its own preferred payment standard based on state law. Defendants likewise err in contending that there is a possibility that the "recovery sought" by the claims could "align with United's payment obligations under the plan terms" because some of those terms allow for "flexibility." *Id.* at 8. Rewriting plan terms that confer discretion on the administrator to instead require some specific payment under state law is, of course, the antithesis of "aligning" with plan terms.

That the Threatened Claims may invoke different potential "legal theories" is likewise immaterial. Def. SJ Br. 8. Regardless of the particular state-law label affixed to them, the Threatened Claims all share the critical features that render them preempted under Section 514: (1) they all seek additional payment beyond the amount permitted under plan terms and (2) none arises under a contract theory, such that the existence of an ERISA plan is the only basis for pinning a payment

obligation on United. *See infra* Part II.A; Dkt. 27, Am. Compl. ¶ 10; *see also, e.g.*, *Rowe Plastic Surgery of N.J., L.L.C. v. Aetna Life Ins. Co*., 2025 WL 1907005, at *4 (E.D.N.Y. July 10, 2025) (recognizing that ERISA preempted "[a]ll of Plaintiffs' state law claims—whatever legal heading they fall under"). For that reason, and contrary to Defendants' assertion, Def. SJ Br. 9-10, none of the Threatened Claims is analogous to the contract or misrepresentation-based causes of action found not preempted in *Plastic Surgery Center, P.A. v. Aetna Life Insurance Co.*, 967 F.3d 218 (3d Cir. 2020), or *Access Mediquip L.L.C. v. UnitedHealthcare Insurance Co*., 662 F.3d 376, 386 (5th Cir. 2011), *adhered to on reh'g en banc*, 698 F.3d 229 (5th Cir. 2012), which all arose from promises the plans made independent of the plan terms. Instead, as discussed below, *see infra* Part II.A.2, all are analogous to claims those decisions recognized *were* preempted. This Court has no need to parse any of the details that Defendants now emphasize in order to conclude that ERISA preempts the Threatened Claims.

Defendants' belated effort to call into question this Court's determination that this dispute involves a concrete and sufficiently immediate controversy is thus unavailing. There is no basis for this Court to decline to exercise its jurisdiction.

II. ERISA Expressly Preempts The Threatened Claims

As United's motion for summary judgment explains in further detail, *see* United SJ Br. 10–25, the Threatened Claims are preempted by ERISA's express

preemption clause, which provides that ERISA "shall supersede any and all State laws insofar as they may … relate to any employee benefit plan." 29 U.S.C. § 1144(a). Each of Defendants' contrary arguments lacks merit.

A. The Threatened Claims "Relate To" ERISA Within The Meaning Of ERISA's Express Preemption Provision

The Supreme Court has long construed Section 514's open-ended "relate to" standard as preempting state laws and claims that either bear a "connection with" or make "reference to" ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983). A claim bears a "connection with" an ERISA plan when, *inter alia*, it seeks to "govern[] a central matter of plan administration" by, for example, requiring "payment of specific benefits" contrary to plan terms. *Rutledge*, 592 U.S. at 87 (quoting *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016)). A claim makes "reference to" an ERISA plan when, *inter alia*, it is "premised on … the existence of a[n ERISA] plan," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990), such that the plan is "essential to the law's operation." *Gobeille*, 577 U.S. at 320 (quotations omitted); *see Rutledge*, 592 U.S. at 88; *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). The Threatened Claims "relate to" ERISA under each of these standards.

1. *The Threatened Claims have a "connection with" ERISA plans*

The Threatened Claims bear a "connection with" ERISA claims because they "govern[] a central matter of plan administration" by requiring "payment of

specific benefits" contrary to plan terms. *Rutledge*, 592 U.S. at 87 (quoting *Gobeille*, 577 U.S. at 320). Claim adjudication and payment—the determination of benefits owed under a plan—represent the core function of "plan administration." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147–48 (2001). Like the plans here, health plans generally promise their members that they will pay for certain out-of-network services, but at rates established by the plan, not at 100% of the provider's billed charges. *See, e.g.*, Dkt. 54-12, Ex. 9 at 81–82 (plan provision requiring United to reimburse certain out-of-network claims at a rate of 110% of the Medicare rate); *see also* Dkt. 54-3, Paradise Decl. ¶ 24 (explaining that this structural feature is common in United plans that offer network and out-of-network benefits, as well as in ERISA plans generally). This important feature of plan design encourages members to seek services from network providers.

Determining what amount to pay for a given claim under the plan terms is a matter of the plan's discretion, subject only to abuse-of-discretion review in court. *See* ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Yet the Threatened Claims seek to override the plan's payment terms by allowing a state court to determine de novo what reimbursement rate is required under state law, which may require the administrator to pay for out-of-network services at rates higher than the plan-specified rate. The plain objective and effect of the Threatened Claims is thus to

"force" the plans "to adopt a certain scheme of substantive coverage," *Gobeille*, 577 U.S. at 320 (quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995)), and to disable "employers from structuring their [health] benefit plans" as they see fit, *Shaw*, 463 U.S. at 97. Section 514 prohibits states from imposing liability on that basis. *See supra* at 13.

Courts have repeatedly applied these principles to deem claims like the Threatened Claims preempted. *See Rowe*, 2025 WL 1907005, at *6 (state-law increased-reimbursement claims preempted because they "would 'require payment of specific benefits' under an ERISA plan"); *AMISUB (SFH), Inc. v. Cigna Health & Life Ins. Co.*, 681 F. Supp. 3d 842, 855–57 (W.D. Tenn. 2023) ("state law claims for failure to pay" preempted because they were "at the heart of issues exclusively under the regulation of ERISA" (quotation omitted)), *aff'd*, 142 F.4th 403 (6th Cir. 2025); *see also Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014) (affirming preliminary injunction against Georgia prompt payment law on preemption grounds because the law caused disuniformity in "processing of claims and disbursement of benefits" by "compel[ling] certain action … by plans and their administrators" (quoting *Egelhoff*, 532 U.S. at 148)).

2. *The Threatened Claims make "reference to" ERISA plans*

The Threatened Claims are also "premised on … the existence of a[n ERISA] plan," *Ingersoll-Rand*, 498 U.S. at 140, because a relationship created by a

plan is the only means by which United could ever be named as a defendant, let alone be held liable, in connection with such a claim. Defendants have no network contracts with United, which would otherwise govern their relationship and fix a specified reimbursement rate for Defendants' services. Absent such contracts, Defendants can seek reimbursement from United only because United is required by an ERISA plan to make payments on participants' behalf, at a rate set by the plan, for services they receive from out-of-network providers.

As the Third Circuit put it in *Plastic Surgery*, when an out-of-network provider asserts a non-contract-based state-law claim seeking to compel the plan administrator to make increased payments on behalf of the plan, such as an unjust enrichment or quantum meruit claim, the administrator is assertedly liable to the provider solely on the basis of the provider's alleged "discharge of the obligation" that the administrator owes to plan beneficiaries. 967 F.3d at 240. That obligation, in turn, is "none other than the insurer's duty to its insured *under the terms of the ERISA plan*" to make payments on plan members' behalf for out-of-network services they receive. *Id.* at 241 (emphasis in original). There would accordingly "simply [be] no cause of action" under non-contractual state law theories "if there [was] no plan." *Id.* at 240–42 (quoting *Ingersoll-Rand*, 498 U.S. at 140).

Every federal appellate court to address the question has agreed with that analysis. *See Park Ave. Podiatric Care, P.L.L.C. v. Cigna Health & Life Ins. Co.,*

2024 WL 2813721, at *2 (2d Cir. June 3, 2024) (concluding that state-law claims for increased reimbursement, including unjust enrichment claim, were preempted because any duty on the administrator's part to pay for "covered services" for the plan member was necessarily "based on [its] obligations as claims administrator for [the patient's] plan," such that the "existence of a [] plan" was "a critical factor in establishing liability" (quoting *Ingersoll-Rand*, 498 U.S. at 139–40)); *Access Mediquip*, 662 F.3d at 386 (unjust enrichment and quantum meruit claims preempted because the provider could "recover under these claims only to the extent that the patients' ERISA plans confer on their participants and beneficiaries a right to coverage for the services provided"). Numerous district court decisions are in accord. *See, e.g.*, *Rowe,* 2025 WL 1907005, at *6 (state-law claims for increased reimbursement preempted because "the only reason why [the administrator] is a defendant, or why Plaintiffs contacted [the administrator], is because of [the patient's] ERISA plan. Absent [the patient's] ERISA plan, there would be no relationship between Plaintiffs and [the administrator] (and no payment to Plaintiffs, even if substantially less than what was expected)"); *Nathaniel L. Tindel, M.D., LLC v. Excellus Blue Cross Blue Shield*, 2023 WL 3318489, at *7 (N.D.N.Y. May 9, 2023) (unjust enrichment claim preempted because "the nature of the benefit allegedly conferred … is premised on the existence of the Plan"); *Cooperman v. Empire HealthChoice HMO, Inc.*, 2025 WL

950675, at *17 (S.D.N.Y. Mar. 28, 2025) (unjust enrichment claim preempted because "the benefit conferred," and thus the liability theory, was "plainly premised on the existence of the Plan"). As each of these courts recognized, an ERISA plan is "essential" to the "operation" of claims like the Threatened Claims, *Gobeille*, 577 U.S. at 320 (quotations omitted), such that the claims "relate to" ERISA and are "squarely preempted," *Plastic Surgery*, 967 F.3d at 242.

B. Defendants' Counterarguments Lack Merit

Faced with the long-settled principles described above dictating express preemption of the Threatened Claims, Defendants' primary argument rests on the Supreme Court's decision in *Rutledge.* Defendants misunderstand that decision, which reinforced, rather than reinvented, the long-settled principles that establish preemption here. Their remaining make-weight arguments are likewise meritless.

1. *Defendants misread the Supreme Court's decision in* Rutledge

The central pillar of Defendants' argument is that *Rutledge* upended the principles set forth above and insulated from preemption all state laws that effectuate "regulation of medical reimbursement rates." Def. SJ Br. 2. That is mistaken. As United's summary judgment motion explained, *see* United SJ Br. 15–19, *Rutledge* did not have the broad effect Defendants ascribe to it. Properly construed, the decision confirms that the Threatened Claims are preempted.

Rather than breaking new ground, *Rutledge* reaffirmed the key rules of ERISA preemption applicable here: 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. 592 U.S. at 86–87. *Rutledge* did not modify the rules of ERISA preemption in any respect, but rather simply applied the principle established years prior in *Travelers* that state laws are not automatically preempted solely by virtue of indirectly increasing plan costs. In *Travelers*, the Supreme Court had rejected preemption of a New York law that imposed surcharges on hospital billing rates for patients covered by particular insurers. 514 U.S. at 668. The law did not directly apply to plans or administrators, but it had the effect of exerting "indirect economic influence" on plans by increasing the underlying costs of the services covered by the plans. *Id*. at 659. The Court held that such indirect economic effects did not establish an "impermissible connection between the New York law and ERISA plans" because the law "did not 'bind plan administrators to any particular choice.'" *Rutledge*, 592 U.S. at 87 (quoting *Travelers*, 514 U.S. at 659). For example, if a plan before the law's enactment promised to reimburse beneficiaries $1000 for a given hospital service, the plan could still promise to pay only $1000 after the law's enactment—leaving the rest as the beneficiary's responsibility. Nothing about the law required the plan or its administrator to alter the type or value of the benefits provided.

In *Rutledge*, the Supreme Court applied the same principle to reject Section 514 preemption of an Arkansas statute that regulated pharmacy benefit managers ("PBMs") and fixed the minimum prices that pharmacies were to be paid for prescription drugs. 592 U.S. at 83–85. The asserted grounds for preemption were that many ERISA plans contracted with PBMs to provide prescription drug benefits, and the statute effectively increased the costs of PBMs (and thus, in turn, of plans that choose to use them). The Supreme Court applied *Travelers* to reject that argument, upholding the law because it simply "establishe[d] a floor for the cost of the benefits that plans choose to provide," which might indirectly affect plan economics, but did not "require plans to provide any particular benefit to any particular beneficiary in any particular way." *Id*. at 90. While the law increased the total cost of covered prescription drugs, it did not require any plan to depart from plan terms that set benefit levels or allocated responsibility for the total bill between the plan and the beneficiary. *Id.* Such a law at most indirectly increased plan costs and "did not 'bind plan administrators to any particular choice.'" *Id.* at 87 (quoting *Travelers*, 514 U.S. at 659).

The Threatened Claims are entirely unlike the laws at issue in *Rutledge* and *Travelers*. In stark contrast to those laws, the Threatened Claims are asserted directly against a plan administrator, challenging payments it makes on behalf of the plan, pursuant to duties prescribed by the plan. What is more, the claims

explicitly seek to bind the administrator to a particular choice, i.e., it must pay certain providers not the amount prescribed by the plan, but whatever amount a jury decides is the appropriate rate under state law—and without regard to the plan's chosen allocation of financial responsibility between the plan and the beneficiary. The Threatened Claims thus explicitly force the administrator, acting on the plan's behalf, to make a different choice than that dictated by the plan.

Defendants thus err in asserting that the PBMs in *Rutledge* "are perfect analogues for [third-party administrators] like United that manage health benefits for the plans." Def. SJ Br. 14–15. Dictating the amount that an administrator must pay on behalf of the plan, as the Threatened Claims would do, has the prohibited effect of holding administrators liable for applying plan-approved reimbursement methodologies and would effectively require plans to cover a different portion of the total bill than the plan design specifies. By contrast, dictating the minimum amount that pharmacies must be paid does nothing to regulate how payment must be allocated among PBMs, plans, and plan participants, and affects ERISA plan costs only indirectly by virtue of market economics.

Recognizing that this distinction makes all the difference, several courts have rejected the interpretation of *Rutledge* urged by Defendants. The *Rowe* court, for example, concluded that *Rutledge* did not save state-law claims analogous to the Threatened Claims from preemption. 2025 WL 1907005, at *6. "*Rutledge* has

no application here," the court explained, because unlike in *Rutledge*, the claim in *Rowe* relied on an ERISA plan's existence to establish liability, since "there would be no relationship between [the provider] and [the administrator]" absent the plan. *Id.*; *see AMISUB*, 681 F. Supp. 3d at 856-57 (finding *Rutledge* inapposite because the state-law claims would "allow[]" plaintiffs "to recover from an entity that directly administers self-funded plans"—an interference with plan administration absent in *Rutledge*); *Long Island Plastic Surgical Grp., P.C. v. Unitedhealthcare Ins. Co. of N.Y., Inc.*, 2026 WL 161152, at *10 (E.D.N.Y. Jan. 21, 2026) (agreeing with the view that *Rutledge* involved a situation "far different than Plaintiff's contention that United must pay the benefits Plaintiff seeks for services provided to members [o]f specific ERISA plans that United allegedly administers").

The contrary cases on which Defendants rely are poorly reasoned, distinguishable, or both. Each misconstrues *Rutledge*, replicating Defendants' error in overlooking the critical distinction between generally applicable cost regulations and claims that require an ERISA plan to pay specific benefits, like the Threatened Claims. *See, e.g.*, *ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514 F. Supp. 3d 927, 940 (S.D. Tex. 2021), *supplemented*, 2021 WL 6617719 (S.D. Tex. Feb. 10, 2021), *and rev'd and*

remanded on other grounds, 60 F.4th 899 (5th Cir. 2023).[2] Beyond that, two of Defendants' cited cases are inapposite because the claims at issue arose from shared savings network contracts. *See Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co*., 658 F. Supp. 3d 1250, 1258 (S.D. Fla. 2023) (claims not preempted because they "arise … from the parties' respective relationships with" shared savings network); *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc*., 2021 WL 4651504, at *3 (S.D. Fla. Sept. 21, 2021) (same). Others, beyond misreading *Rutledge*, failed to understand that the claims demanded payments inconsistent with plan terms. *See, e.g.*, *Emergency Physician Servs. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, at *8 (S.D.N.Y. Sept. 28, 2021) (incorrectly stating that no plan or administrator would be required "to follow a standard inconsistent with those provided by ERISA").

2. *Defendants' other objections to preemption are likewise unavailing*

Defendants' remaining arguments are unpersuasive. *First*, Defendants insist that the Threatened Claims "merely would involve *United's* obligations under state law; they would not impose direct obligations on ERISA plans." Def. SJ Br. 11. The Eleventh Circuit has already rejected that flawed mode of analysis. Presented

[2] Notably, the supplemented opinion in *ACS Primary Care* candidly acknowledged that there was "substantial ground for difference of opinion" as to its preemption ruling, including its "implement[ation]" of *Rutledge*. 2021 WL 6617719, at *1.

with the view that there could be "no 'connection with' ERISA" if a law's "focus is on the regulation of non-fiduciary [third-party administrators]" which are "not 'ERISA entities,'" the Court had little difficulty concluding that "[t]his argument holds no water" given "ERISA's overarching purpose of uniform regulation of plan benefits," which "overshadows this distinction." *Hudgens*, 742 F.3d at 1331 (quotations omitted); *see Gobeille*, 577 U.S. at 323 (determining that a state law that operated through a plan's third-party administrator was preempted). In other words, the preemption analysis requires courts to look beyond the direct target of a law or claim to determine whether its operation would effectuate an impermissible "reference to" or "connection with" ERISA plans. As explained, *see supra* Part II.A, the Threatened Claims have precisely that forbidden effect.

Second, Defendants analogize to *Travelers* and *Dillingham*, insisting that they stand for the proposition that generally applicable state laws cannot be preempted. Not so. That contention overlooks the Supreme Court's directive that a law "refers to" ERISA plans if it "acts immediately and exclusively upon ERISA plans *or* where the existence of ERISA plans is essential to the law's operation." *Rutledge*, 592 U.S. at 88 (emphasis added; quotations omitted). Defendants' stance impermissibly collapses the two prongs of that disjunctive test, overlooking that, as explained, *see supra* Part II.A.2, the Threatened Claims hinge on an ERISA plan's existence. In any event, as explained, *see supra* Part II.A.1, the Threatened Claims

bear no resemblance to laws that operate whether or not an ERISA plan exists because they force the plan itself, or its administrator, to pay unilaterally-demanded amounts instead of the amounts prescribed by plan terms. They are accordingly the antithesis of laws that "function[] irrespective of … the existence of an ERISA plan." *Dillingham*, 519 U.S. at 328 (quotation omitted).

Third, and finally, Defendants contend that ERISA's goals are "in no way obstructed" by the Threatened Claims. Def. SJ Br. 14. Yet they reach that conclusion only by taking a myopic view of those goals. Permitting the Threatened Claims to proceed would contravene one of ERISA's core purposes, namely, to encourage employers to offer benefit plans in part through the promise of predictability afforded by uniform national regulation. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Such a ruling would also disregard the equally fundamental rule that ERISA leaves to employers substantive decisions about what plan benefits to provide, including what rate of reimbursement to promise plan members for care they receive. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). ERISA's goals are therefore served by rigorously enforcing the boundaries of Section 514, which readily encompass the Threatened Claims.

CONCLUSION

The Court should deny Defendants' cross-motion for summary judgment and grant United's motion for summary judgment.

Respectfully submitted,

Dated: April 13, 2026

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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 13th day of April, 2026.

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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

UNITED'S RESPONSE TO DEFENDANT'S STATEMENT OF FACTS IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56 and Northern District of Georgia Local Rule 56.1, Plaintiffs, United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. ("United") set forth this response to Defendants Hospital Physician Services Southeast, P.C.; Inphynet Primary Care Physicians Southeast, P.C.; and Redmond Anesthesia & Pain Treatment, P.C.'s ("Defendants'") Statement of Undisputed Facts in Support of Defendants' Motion For Summary Judgment (Dkt. 79-2).

1.

Plaintiffs, United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. ("United"), are a health insurer and third-party claims administrator ("TPA") for self-funded ERISA plans in Georgia. Declaration of Rebecca Paradise ("Paradise Decl.") ¶ 3. (Dkt. 54-3.) In these roles, United reviews claims for medical services provided to its members and pays reimbursements to the medical providers. Am. Compl., ¶¶ 5, 16, 32. (Dkt. 27.)

United's Response:

Disputed. United objects to paragraph 1, because it contains more than one factual statement in violation of LR 56.1(B)(1). United does not dispute that the employer- and employee-organization sponsored health benefit plans that United administers 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 (the "United Benefit Plans" or the "Plans"), are governed by ERISA. United disputes and objects to the second sentence of paragraph 1, because it cites a "pleading rather than to evidence" in violation of Northern District of Georgia Local Rule 56.1(B)(1)(b), and misstates the pleading. While United does not dispute that it "reviews claims for medical services[,]" it does not always "pay[] reimbursements to the medical providers[.]" United does not dispute that it pays reimbursements for Covered Services consistent with the Plan sponsor-selected rates or methodologies

set forth in the governing Plan document for members covered by fully insured Plans. *See* Paradise Decl. ¶ 5 (Dkt. 54-3). However, when United acts as a TPA for a self-funded Plan, United "reviews claims for medical services" and when the claim is a covered service, 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." *See* Paradise Decl. ¶¶ 6, 20 (Dkt. 54-3).

2.

The Georgia Medical Groups ("GMGs") are medical practices that operate out of hospitals in Georgia. (Dkt. 27, ¶¶ 4, 17–21.) The GMGs contract with those hospitals to provide emergency and non-emergency services to hospital patients. (Dkt. 27, ¶ 4.)

United's Response:

United objects to paragraph 2, because it contains more than one factual statement in violation of LR 56.1(B)(1). Additionally, United objects to this paragraph, because it cites a "pleading rather than to evidence[.]" *See* LR 56.1(B)(1)(b).

3.

The GMGs are affiliated with TeamHealth Holdings, Inc. ("TeamHealth"), a practice management entity with affiliated medical practices in forty-seven states.

See **Exhibit 1**, January 4, 2024 Declaration of Kent Bristow ¶¶ 3, 11. (Dkt. 29-1.)

United's Response:

Undisputed.

4.

Since 2019, other TeamHealth-affiliated practices in other States have filed lawsuits against United. *Id.*

United's Response:

Undisputed.

5.

Those suits have asserted that the rates United paid on commercial, out-of-network emergency services and anesthesia claims were unlawfully low. (Dkt. 29-2; Dkt. 29-3; Dkt. 29-4; Dkt. 29-5; Dkt. 29-6; Dkt. 29-7; Dkt. 29-8; Dkt. 29-9; Dkt. 29-10; and Dkt. 29-11.)

United's Response:

Disputed. United does not dispute that TeamHealth-affiliated practices asserted state common law and statutory claims against United and its affiliates in lawsuits in other states seeking reimbursement above that which United affiliates paid or caused to be paid pursuant to the terms governing their Plan sponsors' Plans in those states. *See, e.g.*, Complaint in *Atl. ER Physicians Team Pediatric Assocs., PA v. UnitedHealth Grp., Inc.* (Dkt. 29-3) (asserting claims for *quantum meruit*;

violation of New Jersey's prompt pay law, and violation of New Jersey's RICO Law, and demanding reimbursement from United at "the full amount of Plaintiffs' billed charges" regardless of Plan terms). United disputes the contention that United "paid" all of the at-issue claims. For "self-funded" Plans, "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 (Dkt. 54-3).

6.

In each of these disputes, United has argued that the TeamHealth-affiliated practices' state law claims are preempted by ERISA to the extent they challenge the rates paid on claims for services delivered to patients holding coverage under self-funded, ERISA-governed Plans. And in each of those cases, the courts have rejected United's argument that ERISA preempted Plaintiffs' state law claims challenging the rates of reimbursement. *See, e.g., Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1297–99 (S.D. Fla. 2021) (emergency medical providers' claims not preempted because "the common law causes of action under which Plaintiffs bring their claims all have force and operate independently of the existence of any ERISA plans" and "the Supreme Court has stated that law which increase[s] the costs plans incur in one state versus another does not necessarily have an impermissible connection with an ERISA plan"); *ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514

F. Supp. 3d 927, 939-42 (S.D. Tex. 2021) (same), *rev'd on other grounds*, 60 F.4th 899 (5th Cir. 2023); *United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in & for Cty. of Clark*, 489 P.3d 915 (Nev. 2021) (same); *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc.*, No. 17-CA-011207 (Fla. 13th Cir. Ct., Hillsborough Cty., Feb. 10, 2019) (same); *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc.*, No. 20-CA-008606 (Fla. 13th Cir. Ct., Hillsborough Cnty., Dec. 1, 2021) (same); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, No. 20-cv-9183 (AJN), 2021 WL 4437166, at *8–9 (S.D.N.Y. Sept. 28, 2021) (same).

United's Response:

Disputed. United objects to paragraph 6, because it contains more than one factual statement and asserts issues and legal conclusions in violation of LR 56.1(B)(1). United disputes Defendants' characterization of the cited decisions and disputes that the courts in all of the referenced cases "rejected United's argument that ERISA preempted Plaintiffs' state law claims," because some of those courts merely denied a motion to dismiss and deferred judgment on the preemption question. *See, e.g.*, Ex. 7 to the Declaration of W. Pollak ("Pollak Decl."), Memorandum of Decision in *Atl. ER Physicians, P.A. v. UnitedHealth Grp., Inc.*, Dkt. No. GLO-L-1196-20 (Aug. 24, 2022, N.J. Sup. Ct.) : ("***At this stage,*** the court finds [TeamHealth] plaintiffs' arguments persuasive.") (emphasis added).

7.

In many of the above-referenced disputes, the TeamHealth-affiliated practices alleged entitlement to "reasonable" or "usual and customary" amounts. (Dkt. 29-2, ¶¶ 192–212; Dkt. 29-3, ¶¶ 292–93, 311, 318; Dkt. 29-4, ¶¶ 5, 7, 40; Dkt. 29-5, ¶¶ 25, 55; Dkt. 29-7, ¶¶ 6, 12.) Furthermore, the legal theories asserted in the above-referenced disputes have varied based on the facts and local law. (Dkt. 29-2, ¶¶ 192–212) (asserting claims under sections 641.513 and 627.64194, Florida Statutes); (Dkt. 29-8, ¶¶ 239–49) (asserting claims under Nevada's Unfair Claim Practices Act); (Dkt. 29-3, ¶¶ 339–66) (asserting RICO claims predicated on theft).

United's Response:

Disputed. United objects to paragraph 7, because it contains more than one factual statement in violation of LR 56.1(B)(1). United disputes Defendants' characterization of the claims advanced by TeamHealth-affiliated practices in other litigations as only seeking "reasonable" or "usual and customary" amounts. Plaintiffs in the cited matters sought to recover their full billed charges and/or amounts beyond both reasonable value and the amounts permitted by Plan terms. *See, e.g.*, Complaint in *Atl. ER Physicians Team Pediatric Assocs., PA*, at ¶ 322 (Dkt. 29-3) (asserting "United is liable to Plaintiffs for the full amount of Plaintiffs' billed charges since Plaintiffs have left United's network"); Complaint in *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*

at ¶¶ 169–240 (Dkt. 54-31) ("Defendants had . . . the common and continuing purpose of. . . preventing the Physicians from obtaining payment . . . at no less than the Physicians' charges or the usual and customary rate for the Physicians' services"); Complaint in *Atl. ER Physicians Team Pediatric Assocs., PA* (Dkt. 29-3) (demanding reimbursement from United at "the full amount of Plaintiffs' billed charges" regardless of Plan terms); *see* Paradise Decl. ¶¶ 9–16 (Dkt. 54-3) (confirming the Plan terms dictate reimbursement). United does not dispute that the precise legal theories or claims asserted in the lawsuits cited in paragraph 8 have varied based on the facts and the state laws at issue.

8.

On November 13, 2023, United filed its original Complaint in this case. (Dkt. 1.) It sought declaratory relief providing that any claims the GMGs theoretically could assert under Georgia state law seeking reimbursement amounts greater than those United has calculated are preempted by ERISA. (Dkt. 1, pp. 36–38.)

United's Response:

Disputed. United objects to paragraph 8, because it contains more than one factual statement in violation of LR 56.1(B)(1). United admits that it filed its original complaint in this case on November 13, 2023 (Dkt. 1), but United disputes Defendants' characterization of the relief sought. United did not seek declaratory

relief that ERISA preempted "any claims the GMGs theoretically could assert under Georgia state law." Rather, as described in the original Complaint, United sought "judgment in its favor declaring that all ***Non-Contractual*** State-Law Claims under Georgia law are preempted by ERISA and the Supremacy Clause of the United States Constitution, as they relate to requests by the TeamHealth Defendants for reimbursement of their claims for out-of-network services to participants and beneficiaries in the United Benefit Plans." Complaint at p. 38 (Dkt. 1) (emphasis added). United specifically defined the "Non-Contractual State-Law Claims" as "claims that provisions or doctrines of state law other than contract principles—such as unjust enrichment, quantum meruit, state RICO laws, common law conversion, civil conspiracy, good faith and fair dealing, or consumer protection law—entitle the affiliates to payment at their full billed charges." Complaint ¶ 10 (Dkt. 1).

9.

On January 5, 2024, the GMGs filed their Motion to Dismiss for Lack of Subject-Matter Jurisdiction, generally arguing that the Court lacks Article III jurisdiction because there is no actual controversy between the parties. Specifically, they contended that the GMGs do not intend to sue United for additional reimbursement under state law and have never given any indication otherwise. (Dkt. 23.)

United's Response:

Disputed. United objects to paragraph 9, because it contains more than one factual statement in violation of LR 56.1(B)(1). United does not dispute that the Defendants filed a motion to dismiss for lack of subject-matter jurisdiction on January 5, 2024 arguing that there was no case or controversy between the parties. United also does not dispute that Defendants contended that they do not intend to sue United on claims accruing prior to April 18, 2025 but United disputes that Defendants have "never given any indication" that they would sue United on such claims, or others. To the contrary, TeamHealth threatened to "pursue[] litigation as a strategy" in 2019 negotiations with United on behalf of TeamHealth-affiliated provider groups and told representatives of United that "the public fight is going to be ugly." *See* April 18, 2019 Email (Dkt. 54-27); Oklahoma Trial Tr. (Day 11) 88:19–89:1, 95:6-11 (Dkt. 54-28). Moreover, Mr. Bristow declined to covenant not to bring suit on future claims for reimbursement under state law in his April 18, 2025 declaration. *See* April 11, 2025 Letter (Dkt. 79-9); April 18, 2025 Bristow Decl. (Dkt. 59-4.).

10.

Rather than respond, United filed its Amended Complaint on January 26, 2024. (Dkt. 27.)

United's Response:

Undisputed.

11.

The only substantive changes in the Amended Complaint consisted of certain new allegations intended to bolster United's position on the existence of an actual controversy. (Dkt. 27, ¶¶ 56, 59–63.)

United's Response:

Disputed. The filing and amendment of United's amended complaint are not material to Defendants' motion. United's choice to amend its complaint to clarify the nature of the dispute between the parties has no bearing on the questions of jurisdiction and ERISA preemption before this Court in Defendants' Motion for Summary Judgment. Whether jurisdiction based on the existence of an actual case or controversy exists is a question this Court must answer based on record evidence—not the breadth of allegations outlined in a pleading. United further disputes that the only changes in the Amended Complaint were to the allegations in paragraphs 56, 59–63. United also made other revisions to the Amended Complaint (*see, e.g.*, revisions to paragraph 57 and 58).

12.

United still did not allege that the GMGs or TeamHealth ever threatened to sue United over any claims in Georgia. (Dkt. 27, ¶ 59; Dkt. 43, p. 8.)

United's Response:

Disputed. TeamHealth's chief executive officer Leif Murphy threatened to sue United. In particular, Leif Murphy told United that TeamHealth has "gotten really good at the litigation route and have a template [complaint] to file in every state for every contract." April 18, 2019 Email (Dkt. 54-27). He also asserted that "[f]or every UHG termination, we'll file a TeamHealth lawsuit." *Id.* He also threatened specifically to bring lawsuits in more states. Oklahoma Trial Tr. 88:19–89:4, 95:12–17 (Day 11) (Dkt. 54-28).

13.

On February 8, 2024, Defendants filed their Motion to Dismiss the Amended Complaint for Lack of Subject Matter Jurisdiction ("First Motion to Dismiss"). (Dkt. 29.)

United's Response:

Undisputed.

14.

After briefing was complete (Dkt. 30 and Dkt. 33), United filed a Leave to File Surreply and a Conditional Motion for Jurisdictional Discovery (Dkt. 38.)

United's Response:

Undisputed.

15.

On July 1, 2024, United filed a Notice of Supplemental Authority. (Dkt. 41.) Thereafter, this Court entered an Order denying the First Motion to Dismiss. (Dkt. 43.) In rendering its decision, the Court stated:

> Stated differently, the record shows that Defendants have submitted claims for services provided to United's members in Georgia and have demanded their full billed charges in each case. The record also demonstrates that United has consistently not paid the full amount and instead followed what it believes is its obligation to pay the claims according to the Plans' reimbursement terms. Under these facts, the Court is satisfied that this case involves "a substantial controversy between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment.
>
> (Dkt. 43, p. 11.)

United's Response:

Undisputed. United objects to paragraph 15, because it contains more than one factual statement in violation of LR 56.1(B)(1).

16.

The Court further found the declaration of Mr. Bristow filed in support of the First Motion to Dismiss "only reflects a present intent not to sue—not a covenant not to ever sue United." (Dkt. 43, p. 9.) The Court found that the declaration did not "negate the possibility of an action in the future regarding the medical claims." (Dkt. 43, p. 10.)

United's Response:

Undisputed. United objects to paragraph 16, because it contains more than one factual statement in violation of LR 56.1(B)(1).

17.

Before Defendants filed their First Motion to Dismiss, United's counsel, Greg Jacob, had sent Kent Bristow, the Senior Vice President of Revenue Management for TeamHealth, a letter requesting that Mr. Bristow, on behalf of the GMGs, execute an attached declaration affirming that the GMGs would not sue United or any of its affiliates using state common law causes of action to seek increased payments on any of the claims at issue in the Geogia (sic) lawsuit. (Dkt. 31; Dkt. 31-1.)

United's Response:

Disputed. United objects to paragraph 17, because it contains more than one factual statement in violation of LR 56.1(B)(1). United's counsel, Greg Jacob, Esq. sent a letter (Dkt. 31-1) to Mr. Bristow on January 23, 2024 in response to the declaration Mr. Bristow signed on January 4, 2024 in support of Defendants' January 5, 2024 motion to dismiss the original complaint (Dkt. 23), which contended that "[p]resently, the [Defendants] have no intent to take action against United regarding the Litigation Medical Claims" at issue, Bristow Decl. ISO MTD ¶ 8 (Dkt. 23-1). In response to this declaration, United's counsel requested that Mr. Bristow "memorialize" TeamHealth's willingness "to retract its prior [litigation] threats" on

behalf of Defendants against United as expressed in his "declaration in support of [Defendants' January 5, 2024] Motion to Dismiss the Complaint" in a new declaration that United's counsel attached to his January 23, 2024 letter. Letter (Dkt. 31-1); *see also* Bristow Decl. ISO MTD (Dkt. 23-1). Mr. Bristow never executed that declaration.

18.

At the time, discovery was in its infancy, and United had not identified the specific claims that were at issue in the Georgia lawsuit. On October 17, 2024, the GMGs served discovery seeking information on the claims at issue in this case. *See* Defendants' First Set of Requests for Production of Documents to Plaintiffs, attached hereto as **Exhibit 2**.

United's Response:

Disputed. United objects to paragraph 18, because it contains more than one factual statement in violation of LR 56.1(B)(1). The date of Defendants' first discovery requests are not material to Defendants' Motion for Summary Judgment, where the Court will rely on evidence. United disputes Defendants' characterization that United had not identified the claims at issue in the Georgia lawsuit as of October 17, 2024. *See* Complaint (Dkt. 1) (outlining the legal claims at-issue in the litigation); Amended Complaint (Dkt. 27) (same).

19.

It was not until January 16, 2025, that United first identified several spreadsheets of claims bearing Bates numbers: UHC0004828, UHC0004829, UHC0004830, UHC0004831, UHC00010442, and UHC00010443, which identified the claims at issue in this action (the "Litigation Medical Claims"). *See* Letter, dated January 16, 2025, from Plaintiffs' counsel, attached hereto as **Exhibit 3**.

United's Response:

Disputed. United does not dispute that it served UHC0004828, UHC0004829, UHC0004830, UHC0004831 on Defendants on January 16, 2025. UHC00010442 and UHC00010443 were served on March 25, 2025. *See* March 25, 2025 Letter (Dkt. 79-6). This dispute is not material to the Court's resolution of the ERISA and jurisdiction questions at issue in the GMGs' Motion for Summary Judgment.

20.

Then, on March 10, 2025, United notified the GMGs that it had identified additional claims at issue in this action and provided two spreadsheets identifying the six additional claims, which were produced on March 25, 2025, bearing Bates numbers UHC00010442 and UHC00010443. *See* Letter, dated March 25, 2025, from Plaintiffs' counsel, attached hereto as **Exhibit 4**.

United's Response:

Undisputed.

21.

On April 1, 2025, one day before United's corporate representative deposition, United informed the GMGs that three claims previously identified as at-issue claims were no longer at issue in the litigation. *See* Letter, dated April 1, 2025, from Plaintiffs' counsel, attached hereto as **Exhibit 5**.

United's Response:

Undisputed.

22.

Following the identification of the Litigation Medical Claims and the close of discovery, Mr. Bristow executed the declaration requested by United verbatim, swearing and unequivocally affirming that:

> [T]he Georgia Medical Groups and TeamHealth and its subsidiaries and affiliates will not bring claims against United or any of its subsidiaries and affiliates for payment of the Litigation Medical Claims at issue in *United Healthcare Services, Inc., et. al. v. Hospital Physician Services Southeast, P.C., et. al.* under state common law theories (save and except for breach of contract theories).

Exhibit 6, Letter, dated April 8, 2025, from Defendants' counsel attaching executed declaration, dated April 8, 2025.

United's Response:

Disputed. United disputes that the declaration signed by Mr. Bristow on April 8, 2025 was identical to the declaration that United attached to its January 23,

2024 letter. To the contrary, over 14 months after "respectfully declin[ing]" to sign the declaration that United attached to its January 23, 2024 letter, Defendants' counsel wrote to United on April 8, 2025 in anticipation of filing a second motion to dismiss and attached a revised version of the proposed declaration signed by Mr. Bristow. *See* January 29, 2024 Letter (Dkt. 31-2) (Mr. Bristow declining to sign the proposed declaration); April 8, 2025 Letter and attachment (Dkt. 79-8). The revised declaration that Plaintiffs sent on April 8, 2025 included a new definition of the "Litigation Medical Claims." April 8, 2025 Letter and attachment (Dkt. 79-8). Specifically, in the revised declaration, Mr. Bristow only swore "not [to] bring claims against United or any of its subsidiaries or affiliates for" claims "identified on Exhibit 1 as UHC0004828, UHC0004829, UHC0004830, UHC0004831, UHC0010442, and UHC0010443." April 8, 2025 Letter and attachment (Dkt. 79-8); Pollak Decl. Ex. 1, Jan. 23, 2024 G. Jacob Letter and attachments. Thus, this revision narrowed the scope of Defendants' covenant not to sue and, as this Court has already held, "the [signed Bristow Declaration] plainly does not insulate United from an action on any claim that may accrue after April 18, 2025." (Dkt. 77, at 10–11).

23.

Upon receipt of the executed declaration, United reneged on its offer to accept the Declaration, as drafted, as sufficient to resolve the issues in this litigation. *See*

Letter, dated April 11, 2025, from Plaintiffs' Counsel, attached hereto as **Exhibit 7**. Instead, United requested a revised declaration, that broadly expanded the scope of any requested relief to not just claims that had already accrued, but to any and all claims that may accrue at any time in the future based on any future facts and circumstances. *Id*.

United's Response:

Disputed. United objects to paragraph 23, because it contains more than one factual statement in violation of LR 56.1(B)(1) and is stated as an issue rather than as a concise fact as required by Local Rule 56.1(B)(2)(a)(1). United disputes Defendants' characterization of United's January 23, 2024 letter as an "offer to accept the Declaration, as drafted, as sufficient to resolve the issues in this litigation." *See* January 23, 2024 Letter (Dkt. 31-1). Mr. Jacob's letter never stated that it would "resolve the issues in the litigation" if Mr. Bristow executed the declaration. Instead, United asked Mr. Bristow to execute the declaration to clarify the meaning and scope of his prior representations. *Id.* United further disputes the GMGs' characterization that United "reneged" on its offer when United asked Mr. Bristow to sign a declaration on April 11, 2025 that protected United from suit in the future on claims accruing after April 18, 2025. *See* April 11, 2025 Letter (Dkt. 79-9); Pollak Decl. Ex. 1, Jan. 23, 2024 G. Jacob Letter and attachments. United further disputes that it "requested a revised declaration, that broadly expanded the scope of

any requested relief to . . . any and all claims that may accrue at any time in the future based on any future facts and circumstances." To the contrary, United requested that Mr. Bristow revise the definition of Litigation Medical Claims to cover non-contractual "state statutory claims, such as Georgia RICO and Georgia consumer protection law claims," "include out of network non-emergency services" in the "pre-2022 set of Litigation Medical Claims" covered by the declaration, and address litigation over non-contractual "claims for out-of-network services delivered by Defendants in Georgia hereafter." *See* April 11, 2025 Letter (Dkt. 79-9).

24.

Despite this change in position, and in order to address certain of United's concerns regarding the scope of Mr. Bristow's declaration, the GMGs revised the declaration to include both state common law theories and state statutory claims, as well as to specifically provide that the declaration is a covenant not to sue. *See* April 18, 2025 Declaration of Kent Bristow, attached hereto as **Exhibit 8**. (Dkt. 59-4.)

United's Response:

Disputed. United objects to paragraph 24, because it contains more than one factual statement in violation of LR 56.1(B)(1). United disputes that it "change[d its] position." United does not dispute that the revised declaration did state that it "is a covenant not to sue on the at-issue Litigation Medical Claims identified on

Composite Exhibit 1." Nor does United dispute that Defendants covenanted not to "bring claims against United or any of its subsidiaries and affiliates for payment of the Litigation Medical Claims at issue in *United Healthcare Services, Inc., et. al. v. Hospital Physician Services Southeast, P.C., et. al.* under state common law theories and state statutory claims (save and except for breach of contract theories)." April 18, 2025 Bristow Decl. ¶¶ 5–6, 8 (Dkt. 59-4). However, Defendants refused United's demand to sign a stipulation that would protect United from the accrual of future claims. *See id.*

25.

> The April 18, 2025 Bristow Declaration affirmed that:
>
> [T]he Georgia Medical Groups and TeamHealth and its subsidiaries and affiliates will not bring claims against United or any of its subsidiaries and affiliates for payment of the Litigation Medical Claims at issue in *United Healthcare Services, Inc., et. al. v. Hospital Physician Services Southeast, P.C., et. al.* under state common law theories and state statutory claims (save and except for breach of contract theories).
>
> This Declaration is a covenant not to sue on the at-issue Litigation Medical Claims identified on Composite Exhibit 1.
>
> * * *
>
> [F[or clarity and the avoidance of any doubt, by this Declaration, the Georgia Medical Groups and TeamHealth and its subsidiaries and affiliates fully and finally extinguish any and all claims seeking increased payment on the Litigation Medical Claims, and any other claim for non-emergent services provided at out-of-network hospitals with a date of service on or before the date of this Declaration.
>
> **Exhibit 8,** ¶¶ 5–6, 8.

United's Response:

Undisputed.

26.

On April 18, 2025, the GMGs filed their Motion to Dismiss Amended Complaint for Lack of Subject-Matter Jurisdiction ("Second Motion to Dismiss") (Dkt. 59) and their Motion to Stay Pending Resolution of Motion to Dismiss (Dkt. 62.)

United's Response:

Undisputed.

27.

On April 24, 2025, the Court granted the GMGs' Motion to Stay, which United did not oppose. *See* April 24, 2025 Paperless Order. Prior to entry of the paperless order, United filed its Motion for Summary Judgment on April 11, 2025. (Dkt. 54.)

United's Response:

Undisputed. United objects to paragraph 27, because it contains more than one factual statement in violation of LR 56.1(B)(1).

28.

On January 12, 2026, the Court entered an Order denying the Second Motion to Dismiss. (Dkt. 77.) In rendering its decision, the Court stated:

> Even though ongoing claims seem unlikely at this time, Defendants fail to affirmatively disclaim that they will never demand full payment or bring suit on a claim accruing after April 18, 2025, should current circumstances change.
>
> …
>
> Ultimately, the covenant plainly does not insulate United from an action on any claim that may accrue after April 18, 2025. The Court thus finds that Defendants fail to meet the "formidable burden" to make it "absolutely clear" that the unlawful conduct (here, demanding payment or threatening suit on insurance claims that are not paid at 100% of the billed charges) will not recur.
>
> (Dkt. 77, pp. 10–11.)

United's Response:

Undisputed. United objects to paragraph 28, because it contains more than one factual statement in violation of LR 56.1(B)(1).

29.

On January 26, 2026, the parties submitted a Joint Motion for Entry of an Order Setting Briefing Schedule on Dispositive Motions (Dkt. 78), which was granted via paperless order on January 27, 2026.

United's Response:

Undisputed.

30.

Pursuant to the April 18, 2025, Declaration of Kent Bristow, the GMGs, and TeamHealth and its subsidiaries and affiliates, fully and finally extinguished any and

all claims seeking increased payment on the Litigation Medical Claims, and any other claim for out-of-network services with a date of service on or before April 18, 2025. **Exhibit 8**, ¶ 8.

United's Response:

United objects to paragraph 30, because it states a legal conclusion in violation of Local Rule 56.1(B)(1)(c).

31.

All of the medical claims identified by United as at-issue in this litigation are no longer at-issue because the GMGs and TeamHealth and its subsidiaries and affiliates have expressly disclaimed their right to sue for any presently existing claim meeting the criteria United set forth in its Amended Complaint. **Exhibit 8**, ¶¶ 5, 8.

United's Response:

Disputed. United objects to paragraph 31, because it states a legal conclusion in violation of Local Rule 56.1(B)(1)(c). United disputes Defendants' characterization, because, as the Court held in its January 12, 2026 Order, "the [signed Bristow Declaration] plainly does not insulate United from an action on any claim that may accrue after April 18, 2025." (Dkt. 77, at 10–11). United also disputes that Defendants and TeamHealth and its subsidiaries and affiliates "have disclaimed their right to sue for any *presently* existing claim," as the Bristow declaration only applies to claims through April 18, 2025. *See* April 18, 2025

Bristow Decl. at 4 (Dkt. 59-4.).

32.

In support of Plaintiffs' Motion for Summary Judgment, Plaintiffs filed the Declaration of Joao C. dos Santos. (Dkt. 54-35.) Mr. dos Santos' declaration states that he 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[.]" (Dkt. 54-35, ¶ 5.)

United's Response:

Undisputed. United objects to paragraph 32, because it contains more than one factual statement in violation of LR 56.1(B)(1).

33.

Mr. dos Santos identified a total of 6,293 claims that United contends are "disputed." (Dkt. 54-35, ¶ 13, Table 3.)

United's Response:

Disputed. United no longer contends the claims Mr. dos Santos identified are still in dispute after the execution of the April 18, 2025 Kent Bristow declaration. *See* April 18, 2025 Bristow Decl. (Dkt. 59-4).

34.

All 6,293 claims that Mr. dos Santos identified are not actually disputed because the GMGs and TeamHealth and its subsidiaries and affiliates have expressly

disclaimed their right to sue on these exact claims. **Exhibit 8**, ¶¶ 5, 8.

United's Response:

United objects to paragraph 34, because it states a legal conclusion in violation of Local Rule 56.1(B)(1)(c).

35.

United is currently out-of-network with the following two Georgia facilities: Children's Healthcare of Atlanta, Hughes Spalding Hospital and Miller County Hospital. *See* Letter, dated March 31, 2025, from Plaintiffs' counsel, attached hereto as **Exhibit 9**.

United's Response:

Undisputed.

36.

The GMGs do not currently provide services, and have never provided services, at Children's Healthcare of Atlanta, Hughes Spalding Hospital or Miller County Hospital. May 28, 2025 Declaration of Sandy Steele, attached hereto as **Exhibit 10**, ¶ 4. (Dkt. 74-1.)

United's Response:

Undisputed.

37.

The Georgia hospitals where Defendants *do* provide services are all in-

network with United. **Exhibit 10**, ¶ 5.

United's Response:

Undisputed.

38.

Any claims that may arise in the future that may be subject to United's Amended Complaint are claims where (1) the underlying medical services for were performed by the GMGs (Dkt. 27); (2) the claims have dates of service after April 18, 2025 (**Exhibit 8**, ¶¶ 5, 8); (3) the claims are for covered, non-emergency out-of-network services provided at out-of-network facilities (Dkt. 54-35, ¶ 9, Table 2); (4) the claims are not subject to the federal No Surprises Act or Georgia's state-specified law (*id.*); (5) the claims are not HMO claims or fully insured indemnity claims (*id.*); and (6) the claims are for services provided to United members holding health coverage under ERISA-governed health plans (*id.*).

United's Response:

Undisputed.

39.

United provides two types of health benefit plans: "fully insured" and "self-funded" plans. (Dkt. 54-3, ¶¶ 3–6.)

United's Response:

Disputed. United does not dispute that they administer "fully-insured" and

"self-funded" (also called "self-insured") Plans in Georgia. Paradise Dec. ¶¶ 3–6 (Dkt. 54-3). United denies Defendants' characterization that United *only* provides two types of Plans, which is unsupported by the cited portion of Rebecca Paradise's Declaration, because United provides more than two types of health benefit plans. *See* Paradise Dec. ¶¶ 3–6 (Dkt. 54-3).

40.

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. (Dkt. 54-3, ¶ 5.)

United's Response:

Undisputed.

41.

For fully insured plans, the governing plan document is typically referred to as a "Certificate of Coverage" or "COC." (Dkt. 54-3, ¶ 8.)

United's Response:

Undisputed.

42.

For "self-funded" or "self-insured" plans, the plan sponsor remains financially responsible but pays a fee to United to act as a TPA, meaning United builds and

provides participants access to provider networks, reviews and adjudicates claims, maintains claim payment and other records, communicates with participants and beneficiaries, handles appeals, and provides other services. (Dkt. 54-3, ¶ 6.)

United's Response:

Undisputed.

43.

For self-insured plans, the governing plan document is typically referred to as a "Summary Plan Description" or "SPD." (Dkt. 54-35, ¶ 8.)

United's Response:

Undisputed.

44.

Both SPDs and COCs have different reimbursement protocols for different types of services. For example, the Delta Account-Based Healthcare Plan Healthcare Benefits Handbook, effective January 1, 2019, states that:

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.

Exhibit 11, UHC0000465–UHC0000828, at UHC0000555. In contrast, covered services that do not meet the above criteria are reimbursed as follows:

> - 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 . . . .
>
> - If there is not an established Medicare-allowable charge, UHC uses an available 'gap methodology' to determine a rate for the service . . . .
>
> - 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[.]

Id. at UHC0000556–57.

United's Response:

Undisputed that SPDs and COCs specify varying reimbursement protocols, and that the cited Delta Account-Based Healthcare Plan Healthcare Benefits Handbook is an example of one of them. United objects to paragraph 44, because it contains more than one factual statement in violation of LR 56.1(B)(1).

45.

Different SPDs and COCs also have different reimbursement amounts for the same type of services. For example, the COC for Insperity Holdings, Inc. states that for out-of-network services where the rate has not been negotiated, the allowed amounts are determined based on 110% of the published rates allowed by CMS. *See* **Exhibit 12**, UHC0001798–UHC0001991, at UHC0001838. In contrast, the SPD for Love's Travel Stops and Country Stores, Inc. states that for out-of-network services where the rate has not been negotiated, the allowed amounts are determined based on 140% of the published rates allowed by CMS. **Exhibit 13**, UHC0009617–UHC0009797, at UHC0009637. In further contrast, the SPD for Caterpillar Inc. provides that

> [w]hen Covered Health Services are received from non-Network Providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (i) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area (Usual and Customary), or (ii) applying the negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, designees, or subcontractors.

Exhibit 14, UHC0001667–UHC0001797, at UHC0001789.

United's Response:

Disputed. United objects to paragraph 45, because it contains more than one factual statement in violation of LR 56.1(B)(1). United does not dispute that the

quoted language appears in the cited documents and does not dispute that different Plans reimburse the same types of services differently based on Plan sponsor elections reflected in the Plan documents. Paradise Dec. ¶ 12 (Dkt. 54-3). But United disputes Defendants' characterization of the Plan documents as incomplete or oversimplified. For example, while the Insperity, Inc. COC does indicate allowed amounts may be based on "110% of the published rates allowed by [CMS] . . .for the same or similar service within the geographic market," it also outlines a "gap methodology" for scenarios where a CMS rate is unavailable. *See* Insperity, Inc. COC (Dkt. 79-14 at UHC0001838-39). The same is true for Love's Travel Stops and Country Stores, Inc. and Caterpillar, Inc, where Defendants omitted detail describing how United calculates Eligible Expenses pursuant to Plan sponsor elections. *See* Love's Travel Stops and Country Stores, Inc. SPD (Dkt. 79-15 at UHC0009637-38) (describing the Plan sponsor's elected methodology for determining Eligible Expenses, including the "gap methodology" for scenarios where CMS rates are not available); Caterpillar Inc. SPD (Dkt. 79-16 at UHC0001789) (describing the "methodologies" that can be used to determine "Eligible Expenses").

46.

Another one of the SPDs for a medical claim that United contends is disputed in this case is the SPD for Sotera Health Holdings, LLC, effective January 1, 2022.

See **Exhibit 15**, UHC0007742–UHC0007920 ("Sotera SPD").

United's Response:

Disputed. United no longer contends the Sotera claim is disputed as the date of service was in April 2022 and Mr. Bristow has expressly covenanted not to bring suit on any claims prior to April 18, 2025. *See* April 18, 2025 Bristow Decl. ¶¶ 4-6 (Dkt. 59-4) .

47.

The Sotera SPD is a plan "governed by ERISA." *Id.* at UHC0007744.

United's Response:

Undisputed.

48.

The Sotera SPD defines Plaintiff United Healthcare Services, Inc. as the "Claims Administrator." *Id*. As the Claims Administrator, Plaintiff United Healthcare Services, Inc. determines the Allowed Amounts that the plan will pay for benefits. *Id*. at UHC0007781 ("Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.").

United's Response:

Undisputed. United objects to paragraph 48, because it contains more than one factual statement in violation of LR 56.1(B)(1).

49.

The Sotera SPD further provides that "[w]hen Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows . . . ." *Id.* at UHC0007782. The Sotera SPD then lists the following scenarios: (1) "non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians," (2) "Emergency Health Care Services provided by an out-of-Network provider," and (3) "Air Ambulance transportation provided by an out-of-Network provider." *Id.* at UHC0007782–83. The Sotera SPD then states that "[w]hen Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined, based on one of the following: Negotiated rates agreed to by the out-of-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates, or subcontractors." *Id.* at UHC0007783.

United's Response:

United objects to paragraph 49, because it contains more than one factual statement in violation of LR 56.1(B)(1).

50.

The Sotera SPD also gives Plaintiff United Healthcare Services, Inc. discretion to determine the allowed amounts on particular claims. Specifically, the

Sotera SPD states, under the section titled "Advocacy Services," that

> Your plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-Network providers that have questions about the Allowed Amount and how the Claims Administrator determined those amounts . . . . In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, believes that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim.
>
> *Id.*

United's Response:

Disputed. United objects to paragraph 50, because it contains more than one factual statement in violation of LR 56.1(B)(1). United does not dispute that the quoted language appears in the Sotera SPD. Sotera Health Holdings, LLC SPD ("Sotera SPD") at UHC0007783 (Dkt. 79-17). While the Sotera SPD grants United discretion to at times pay on behalf of the Plan sponsor amounts that are higher than the elected Allowed Amount, the instructions make clear they should *only* do so where the decision will serve the best interest of the plan or its participants. *Id.* Moreover, the Allowed Amount under the plan in these circumstances does not change. *Id.* Instead, Sotera has elected to include plan terms permitting United to pay above the Allowed Amount when United determines doing so is warranted to

protect the plan and its participants' interest by, for example, "avoiding costs and expenses of disputes over payment of claims" in one-off cases. *See id.*

51.

Certain ERISA health plans delegate to United flexibility to decide out-of-network reimbursement amounts. *See id*. ("[I]f the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, believes that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim."); **Exhibit 16**, UHC0004998–UHC0005197 (SPD for Southwest Airlines Co.), at UHC0005042 ("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."); **Exhibit 14**, UHC0001789 ("When Covered Health Services are received from non-Network Providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (i) calculating Eligible Expenses based on available data resources of competitive

fees in that geographic area (Usual and Customary), or (ii) applying the negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, designees, or subcontractors.").

United's Response:

Disputed. United objects to paragraph 51, because it contains more than one factual statement in violation of LR 56.1(B)(1).

United does not dispute that the quoted language appears in the Sotera SPD. Sotera SPD at UHC0007783 (Dkt. 79-17). While the Sotera SPD grants United discretion to at times increase the Allowed Amount for particular claims, the instructions make clear it should *only* do so where it believes the decision will serve the best interest of the plan or its participants. *Id.* Moreover, the initial Allowed Amount under the plan in these circumstances does not change. *Id.* Instead, Sotera has elected to include plan terms permitting United to pay above the Allowed Amount when United determines doing so is warranted to protect the plan and its participants' interest by, for example, "avoiding costs and expenses of disputes over payment of claims" in one-off cases. *See id.*

United also does not dispute that the quoted language appears in the Southwest Airlines SPD. Southwest Airlines Co. SPD at UHC0005042 (Dkt. 79-18). United disputes Defendants' characterization of United's discretion to reimburse

emergency claims. The Southwest Airlines SPD establishes the following methodology for determining Eligible Expenses:

> (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. *Id.*

United must determine Eligible Expenses pursuant to this methodology elected by the Plan sponsor. *Id.*

United also does not dispute that the quoted language appears in the Caterpillar Inc. SPD (Dkt. 79-16). United disputes Defendants' characterization of the scope of the discretion delegated to United. The Caterpillar SPD also specified that Eligible Expenses "must be a Covered Health Service . . . and must not exceed the fees that the Provider would charge any similarly situated payor for the same services." Caterpillar Inc. SPD at UHC0001789 (Dkt. 79-16). The Caterpillar SPD also establishes the following methodology for determining Eligible Expenses:

> "Eligible Expenses are determined in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:
>
> - As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;

- As reported by generally recognized professionals or publications;
- As used for Medicare; and/or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts." Caterpillar Inc. SPD at UHC0001789 (Dkt. 79-16).

United must determine Eligible Expenses pursuant to this methodology elected by the Plan sponsor. *Id.*

Respectfully submitted,

Dated: April 13, 2026

/s/ Greg Jacob

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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.

/s/ Greg Jacob

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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 13th day of April, 2026.

/s/ Greg Jacob
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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

DECLARATION OF WILLIAM D. POLLAK, ESQ. IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' 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 Opposition to Defendants' Motion, ECF 79. 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 1 is a true and correct copy of the January 23, 2024 letter from Plaintiffs' counsel, Greg Jacob, and attachments.

3. Attached hereto as Exhibit 2 is a true and correct copy of a March 31, 2026 United Healthcare press release, "An Update Regarding Our Network Negotiation with WakeMed," available at https://www.uhc.com/wakemed?msockid=0f60dc028ad369961caecb0e8be16877.

4. Attached hereto as Exhibit 3 is a true and correct copy of a November 19, 2025 University of South Alabama Health press release, "Insurance Contracts with UnitedHealthcare Expire after Months of Negotiations," available at https://www.usahealthsystem.com/news/unitedhealthcare-expiration-providence.

5. Attached hereto as Exhibit 4 is a true and correct copy of an April 3, 2026 article, "CommonSpirit, Cigna Reach Agreement for Tennessee, Georgia," by Jakob Emerson and Elizabeth Casolo published in *Becker's Hospital Review*, available at https://www.beckershospitalreview.com/finance/commonspirit-cigna-go-out-of-network-in-tennessee-georgia/.

6. Attached hereto as Exhibit 5 is a true and correct copy of a December 1, 2025 article, "UNC Health-Cigna Talks Fail, Leaving Over 65,000 Patients Without In-Network Coverage," by Chantal Allam, published in *News & Observer*, available at https://www.newsobserver.com/news/business/article313284070.html.

7. Attached hereto as Exhibit 6 is a true and correct copy of a December 11, 2025 United HealthCare press release, "An Update Regarding Our Negotiation with Northeast Georgia Health System," available at https://www.uhc.com/nghs?msockid=0f60dc028ad369961caecb0e8be16877.

8. Attached hereto as Exhibit 7 is a true and correct copy of a Memorandum of Decision in *Atlantic ER Physicians, P.A., et al. v. UnitedHealth Group, Inc., et al.*, Dkt. No. GLO-L-1196-20 (Aug. 24, 2022, N.J. Sup. Ct.).

9. Attached hereto as Exhibit 8 is a true and correct copy of a Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) press release, "Advocating For You: Memorial Healthcare System Chose to Go Out-of-Network as of September 1, 2025—Florida Blue Is Continuing To Negotiate For You," available at https://www.floridablue.com/negotiation/memorialhealthcare.

10. Attached hereto as Exhibit 9 is a true and correct copy of an Order in *Northeast Georgia Medical Center. Habersham, LLC v. United Healthcare of Georgia, Inc.*, No. 2024CV000529 (Aug. 1, 2025, Ga. Super. Ct., Hall Cnty.).

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

Executed this 13th day of April, 2026 in New York, New York.

/s/
William D. Pollak

Exhibit 1

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January 23, 2024

Greg Jacob
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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[1] 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,

[1] 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.[2] 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,

Greg Jacob

[2] 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 1

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

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.	Case No. 1:23-cv-05221-JPB

DECLARATION OF KENT BRISTOW
IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS
FOR LACK OF SUBJECT-MATTER JURISDICTION

In accordance with 28 U.S.C. § 1746, I, Kent Bristow, hereby declare as follows:

1. My name is Kent Bristow. I am over eighteen (18) years old, and I have personal knowledge of the matters set forth in this Declaration. If called to testify to the facts stated herein, I could and would do so competently.

2. This Declaration is made in support of Defendants' Motion to Dismiss for Lack of Subject-Matter Jurisdiction (the "Motion").

3. I am the Senior Vice President, Revenue Management for TeamHealth Holdings, Inc., a term commonly used to refer to an affiliated group of companies that provide practice management services to medical professionals ("TeamHealth"). I have held that position for approximately ten years. I have worked with TeamHealth and its affiliates for over 25 years.

4. As Senior Vice President, Revenue Management, my responsibilities include, for example, overseeing managed care contracting and negotiations and overseeing disputes with insurance companies related to billing and reimbursement for TeamHealth-affiliated medical practices. In general, these medical practices also appoint me as authorized agent with power and authority to enter into managed care agreements and to oversee business processes related to managed care relationships on their behalf. The medical practices include the Defendants in this matter: Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. (collectively the "Georgia Medical Groups"). The Georgia Medical Groups are distinct corporate entities, with their own corporate governance.

5. In my roles, I am familiar with the relationship between the Georgia Medical Groups and Plaintiffs United HealthCare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. (collectively "United") in Georgia. My knowledge includes the Georgia Medical Groups' and United's course of dealing,

billing and reimbursement issues between the parties, and the facts and circumstances of this lawsuit.

6. I understand that in this lawsuit, United has put at issue the following specific claims for medical services rendered by the Georgia Medical Groups in Georgia: (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 (the "Litigation Medical Claims").

7. In my roles, I have the authority to determine what reimbursement rates are acceptable to TeamHealth and its affiliates, including the Georgia Medical Groups, and whether to take legal action against health insurers and/or third-party administrators (collectively, "Insurers"), such as United, regarding inadequate rates of reimbursement.

8. Presently, the Georgia Medical Groups have no intent to take legal action against United regarding the Litigation Medical Claims.

9. Additionally, I am unaware of any indication that the Georgia Medical Groups or TeamHealth has given United that the Georgia Medical Groups intend to take action regarding the Litigation Medical Claims.

10. TeamHealth-affiliated medical groups are located in forty-seven states. These medical groups are selective and deliberate about whether and when to take legal action against Insurers. Therefore, a decision for a TeamHealth-affiliated medical group in a certain geographic market to bring an action against an Insurer is not indicative of an intent for different affiliates in different markets to do the same.

11. To date, TeamHealth-affiliated medical groups have sued United in only nine out of the forty-seven States in which they operate.

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

Executed on January 4th, 2024

Kent Bristow

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.	Case No. 1:23-cv-05221-JPB

DECLARATION OF KENT BRISTOW

In accordance with 28 U.S.C. § 1746, I, Kent Bristow, hereby declare as follows under penalty of perjury:

1. My name is Kent Bristow. I am over eighteen (18) years old, and I have personal knowledge of the matters set forth in this Declaration. If called to testify to the facts stated herein, I could and would do so competently.

2. I am the Senior Vice President, Revenue Management, for TeamHealth Holdings, Inc. ("TeamHealth"). As Senior Vice President, Revenue Management, my responsibilities include overseeing disputes with insurance companies related to billing and reimbursement for TeamHealth affiliated medical practices, including the Defendants in the above-captioned lawsuit—Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians

Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. (the "Georgia Medical Groups").

3. In my roles, I have the authority to determine whether the Georgia Medical Groups take, or refrain from, legal action against health insurers such as United Healthcare Services, Inc., United Healthcare Insurance Company, and UMR, Inc. (collectively, "United").

4. I understand that the above-captioned litigation involves claims for medical services rendered by the Georgia Medical Groups 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 (collectively, "the Litigation Medical Claims").

5. I swear and affirm that the Georgia Medical Groups and TeamHealth and its subsidiaries and affiliates will not bring claims against United or any of its subsidiaries or affiliates for payment of the Litigation Medical Claims at issue in *UnitedHealthcare Services Inc., et al. v. Hospital Physician Services Southeast, P.C. et al.* under state common law theories (save and except for breach of contract theories).

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

Executed on January __, 2024

_____

Kent Bristow

Exhibit 2

Updated March 31, 2026

Wakemed (NC)

An update regarding our network negotiation with WakeMed

We have been actively negotiating in good faith with WakeMed with the goal of reaching an agreement that restores network access to the health system. We were encouraged by the recent progress in our negotiation, including agreement on the rates we'd reimburse WakeMed's physicians.

Unfortunately, WakeMed recently reversed course. Instead of continuing toward a reasonable resolution, the health system introduced new demands that included significant price hikes that were well beyond what had previously been discussed.

WakeMed is now seeking a near 30% rate increase for its physicians in one year, nearly 10 times more than what our organizations had aligned on verbally.

WakeMed is also demanding a 12% price hike in one year for its hospitals, which is more than double what the health system had previously proposed. Additionally, WakeMed is asking to be paid the same rates as the top academic medical centers in the state by the end of the second year of our contract. This would represent another significant increase in health care costs for North Carolinians and employers.

WakeMed's demands ignore the reality of how contracts are negotiated, which consider the type of services provided, quality of care, cost and many other factors.

It remains our top priority to reach an agreement. We remain ready to engage in discussions should WakeMed provide a proposal that's affordable and sustainable for North Carolinians and employers.

However, should WakeMed maintain its current position, no agreement will be reached and the health system will remain out of network long-term.

In the meantime, we want to remind you that you continue to have access to a broad network of providers throughout the Raleigh area, including Duke Health and UNC Health. Please call the number on your health plan ID card or access our provider directory at myuhc.com if you need assistance finding another provider in your area.

WakeMed chooses to leave UnitedHealthcare's network

WakeMed has allowed our contract to expire after refusing to move off its demands for unreasonable rate increases. As a result, WakeMed's facilities and specialty providers are out of

network for people enrolled in the following plans, effective Nov. 15, 2025:

- Employer-sponsored and individual commercial plans
- Medicare Advantage plans, including Group Retiree, and Dual Special Needs Plan (DSNP)

Our goal throughout this negotiation has always been to reach an agreement that is affordable for consumers and employers while maintaining continued, uninterrupted network access to WakeMed. We made numerous compromises, including proposing rates that would have continued to reimburse WakeMed at market-competitive rates.

Unfortunately, WakeMed maintained its demands for unsustainable rate increases, which would increase health care costs for North Carolinians and employers.

While we remain open to discussions with WakeMed, our primary focus at this time is providing our members uninterrupted access to the care they need through either continuity of care or supporting them as they transition to new care providers.

We know that network changes can be difficult, but our members can rest assured that they will continue to have access to quality, affordable care from a broad network of hospitals and physicians.

We know WakeMed choosing to leave our network is difficult

We want you to know you continue to have access to a broad network of hospitals and physicians across the Raleigh area, including, but not limited to:

- UNC Rex Hospital
- UNC Medical Center
- UNC Health Johnston
- UNC Health Johnston in Clayton
- Duke Raleigh Hospital
- Duke Regional Hospital
- Duke University Medical Center
- Wilson Medical Center

- Cape Fear Valley Central Harnett Hospital

If you have questions or are in need of assistance finding alternative providers in your area, please call us at the number on your health plan ID card. You can also visit your plan's website:

- **myuhc.com**
- **myuhcmedicare.com**
- **retiree.uhc.com** for Group Retiree plans

If a member needs assistance transitioning to a different provider, they can also call the phone numbers below, which offer prioritized appointment access within the UNC Health and Duke Health systems to help ensure uninterrupted care:

- UNC Health: **984-974-CARE** [2273]
- Duke Health: **919-416-3853**

Frequently asked questions

What is the status of the negotiation between UnitedHealthcare and WakeMed?

Despite our repeated efforts to reach a compromise, WakeMed has chosen to leave UnitedHealthcare's network. As a result, WakeMed's facilities and specialty providers are out of network for people enrolled in the following plans, effective Nov. 15, 2025:

- Employer-sponsored and individual commercial plans
- Medicare Advantage plans, including Group Retiree, and Dual Special Needs Plan (DSNP)

Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in network. People enrolled in our Medicaid plans will continue to have network access to WakeMed's hospitals and providers. People enrolled in a Medicare Supplement plan can also continue accessing care with WakeMed on and after Nov. 15, 2025.

Our goal throughout this negotiation has always been to reach an agreement that is affordable for consumers and employers while maintaining continued, uninterrupted network access to WakeMed. We made numerous compromises, including proposing rates that would have continued to reimburse WakeMed at market-competitive rates.

Unfortunately, WakeMed refused to move off its demands unreasonable price hikes. If we agreed to WakeMed's unsustainable proposal, health care costs for North Carolinians and employers would significantly increase.

While we remain open to discussions with WakeMed, our primary focus at this time is providing our members uninterrupted access to the care they need through either continuity of care or supporting them as they transition to new care providers. We know that network changes can be difficult, but our members can rest assured that they will continue to have access to quality, affordable care from a broad network of hospitals and physicians.

When does UnitedHealthcare's contract with WakeMed end?

WakeMed's facilities and specialty providers in the Raleigh region are out of network for people enrolled in the following plans, effective Nov. 15, 2025:

- Employer-sponsored and individual commercial plans
- Medicare Advantage plans, including Group Retiree, and Dual Special Needs Plan (DSNP)

Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in network.

People enrolled in our Medicaid plans will continue to have network access to WakeMed's hospitals and providers.

People enrolled in a Medicare Supplement plan can also continue accessing care with WakeMed on and after Nov. 15, 2025.

Can I continue to receive in-network care from my WakeMed primary care physician now that the health system has chosen to leave UnitedHealthcare's network?

Yes. Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in-network, regardless of the outcome of our negotiation.

What hospitals are impacted by this negotiation?

The following hospitals are out of network, effective Nov. 15, 2025:

- WakeMed Cary Hospital
- WakeMed Raleigh Campus

- WakeMed North Hospital

What benefit plans are impacted by the negotiation?

This negotiation impacts members enrolled in the following plans:

- Employer-sponsored and individual commercial plans
- Medicare Advantage plans, including Group Retiree, and Dual Special Needs Plan (DSNP)

Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in network.

People enrolled in our Medicaid plans will continue to have network access to WakeMed's hospitals and providers.

People enrolled in a Medicare Supplement plan can also continue accessing care with WakeMed on and after Nov. 15, 2025.

Are members enrolled in UnitedHealthcare's Medicare Advantage and Group Retiree plans still be able to receive care from WakeMed now that its hospitals and specialty providers are out of network?

People enrolled in our Medicare Advantage PPO and Group Retiree plans may receive care from an out-of-network provider, if the provider is a Medicare participating provider which accepts the plan.

If people have a Group Retiree PPO plan, their share of the cost is typically the same as if the provider was part of the network.

Members enrolled in our Medicare Advantage PPO and Group Retiree plans are encouraged to speak with the provider to confirm they will provide care, regardless of their network status.

Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in network.

For support finding in-network hospitals, members can call the customer care number on their health plan ID card or visit their plan's website:

- **myuhc.com**

- **myuhcmedicare.com**
- **retiree.uhc.com** for Group Retiree plans

Where else can a member go for care now that WakeMed has chosen to leave UnitedHealthcare's network?

Our members will continue to have access to a broad network of hospitals and specialty providers across the Raleigh area, including, but not limited to:

- UNC Rex Hospital
- UNC Medical Center
- UNC Health Johnston
- UNC Health Johnston in Clayton
- Duke Raleigh Hospital
- Duke Regional Hospital
- Duke University Medical Center
- Wilson Medical Center
- Cape Fear Valley Central Harnett Hospital

Primary care physicians employed by WakeMed are not impacted by this negotiation and will remain in network.

People enrolled in our Medicaid plans will continue to have network access to WakeMed's hospitals and providers.

People enrolled in a Medicare Supplement plan can also continue accessing care with WakeMed on and after Nov. 15, 2025.

For support finding in-network hospitals, members can call the customer care number on their health plan ID card or visit their plan's website:

- **myuhc.com**
- **myuhcmedicare.com**
- **retiree.uhc.com** for Group Retiree plans

What if a member is in the middle of treatment at a WakeMed hospital or with a WakeMed specialty provider now that the health system has chosen to leave UnitedHealthcare's network?

UnitedHealthcare members who are in the middle of treatment at a WakeMed hospital or with a WakeMed specialty provider may qualify for continuity of care, which provides continued in-network benefits for a specified period of time after a hospital or physician leaves our network.

Examples of patients who may qualify include:

- Women who are pregnant
- Patients with newly diagnosed or relapsed cancer, or those currently in active cancer treatment.

People who have questions about continuity of care, including whether they might be eligible and how to apply, should call the number on the back of their health plan ID card.

Where can a member go in the event of an emergency now that WakeMed has chosen to leave UnitedHealthcare's network?

UnitedHealthcare members should always go to the nearest hospital in the event of an emergency. Their services will be covered at the in-network benefit level, regardless of whether the hospital participates in UnitedHealthcare's network.

Where can I find additional information about in-network hospitals and physicians?

For support finding in-network hospitals, members can call the customer care number on their health plan ID card or visit their plan's website:

- **myuhc.com**
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- **retiree.uhc.com** for Group Retiree plans

Exhibit 3

GENERAL NEWS [HTTPS://WWW.USAHEALTHSYSTEM.COM/NEWS?CATEGORY=GENERAL-NEWS]

Insurance contracts with UnitedHealthcare expire after months of negotiations

UnitedHealthcare policyholders will continue to have in-network insurance coverage at all other USA Health facilities, including University Hospital, Children's & Women's Hospital, the Freestanding Emergency Department and all clinics.

Published Nov 19th, 2025

Health insurance contracts between UnitedHealthcare and USA Health Providence Hospital have expired, meaning that UnitedHealthcare members no longer have in-network coverage for services provided at Providence Hospital and may face higher out-of-pocket costs.

The expired contracts apply to both employer-sponsored commercial and exchange plans and Medicare Advantage plans.

“We understand how important uninterrupted access to care is for our patients,” said Natalie Fox, DNP, CEO of USA Health. “Unfortunately, after five months of negotiations, USA Health and UnitedHealthcare could not reach an agreement to ensure patients continue to receive in-network coverage at Providence Hospital.”

UnitedHealthcare policyholders will continue to have in-network insurance coverage at all other USA Health facilities, including University Hospital, Children’s & Women’s Hospital, the Freestanding Emergency Department and all clinics.

As a not-for-profit academic health system, USA Health relies on fair partnerships with insurance companies to continue offering advanced treatments, innovative research, and access to skilled providers for patients, Fox said.

Patients who have questions about access to coverage at Providence Hospital can call the phone number on the back of their insurance card for information about physicians and hospitals that accept UnitedHealthcare insurance.

Plans currently accepted by Providence Hospital include:

- Blue Cross Blue Shield of Alabama – Commercial and Medicare Advantage
- Blue Cross Blue Shield of Mississippi – Blue Card
- Humana – ChoiceCare, Military Tricare – AL, Medicare Advantage HMO and PPO
- Cigna – Commercial and Cigna Healthspring – Medicare Advantage
- Aetna - Commercial and Medicare Advantage
- Viva – Health and Medicare Advantage
- Medicaid – Alabama and Mississippi
- Medicare – Alabama and Railroad
- Ambetter – Alabama and Mississippi Exchange/Marketplace plans
- Devoted Health – Medicare Advantage
- Magnolia – Mississippi Exchange Plan
- Mississippi Physician Care Network – MPCN – PPO
- Molina – Mississippi CHIP – CAN – Exchange
- Multiplan Inc – Alabama
- Trucare of Mississippi
- Wellcare of Mississippi – Medicare Advantage

UnitedHealthcare policyholders can also learn more by visiting usahealthsystem.com/united [https://www.usahealthsystem.com/united] .

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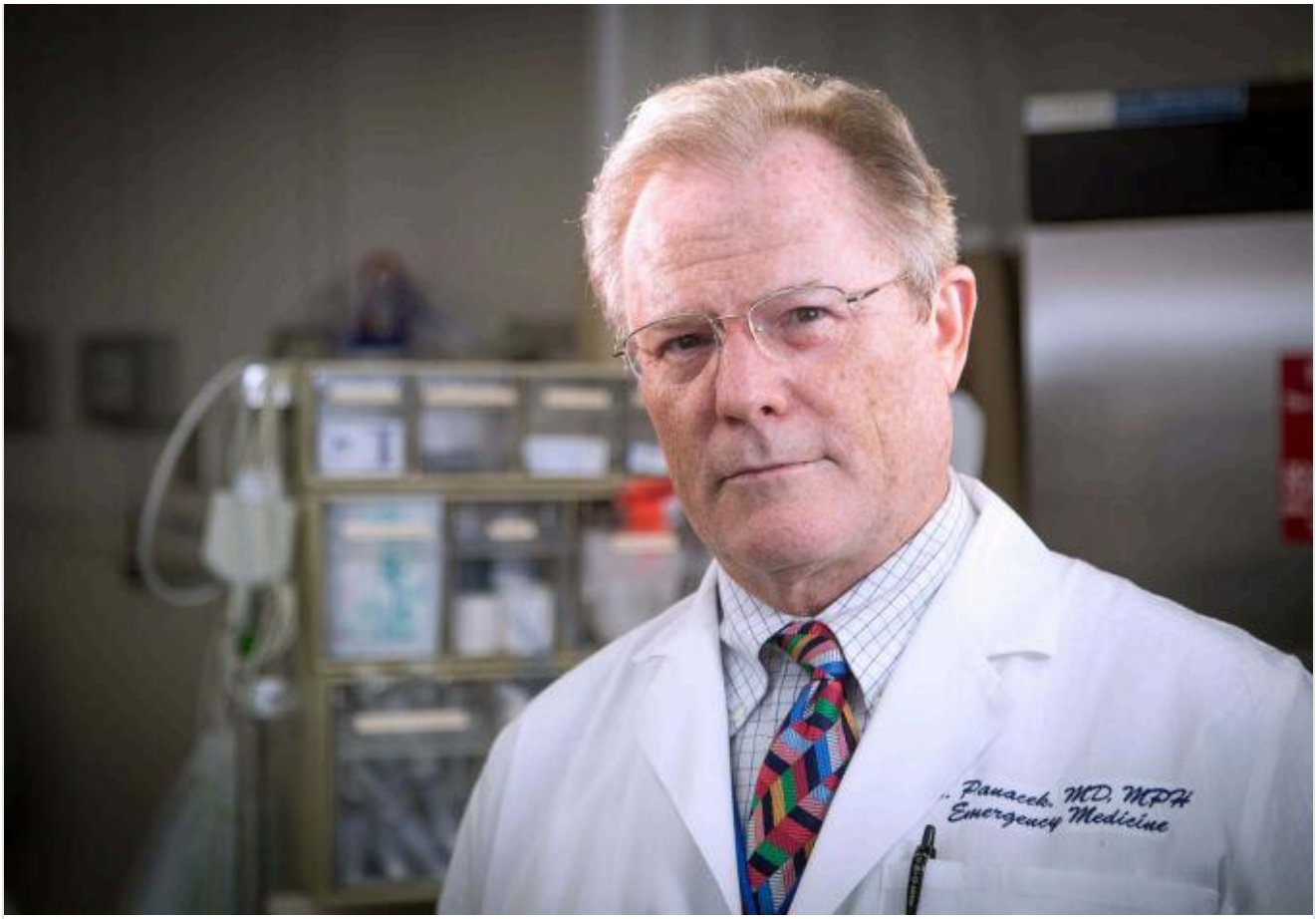

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USA Health emergency medicine leader earns International Educator Award

[https://www.usahealthsystem.com/news/usa-health-emergency-medicine-leader-earns-international-educator-award]

For years, Edward Panacek, M.D., MPH, has helped young investigators in countries where medical research is underdeveloped, assisting them in editing content for posters or podium presentations, and offering guidance on manuscript writing.

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How University Hospital's Care Closet is transforming patient care beyond the bedside

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Plans are underway to host clothing drives throughout the year to support and expand the mission, ensuring the University Hospital Care Closet remains a lasting resource for patients and the community.

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USA Health names Idriss interim medical director of hepatology

[https://www.usahealthsystem.com/news/idriss-interim-medical-directo-hepatology]

With a specialist in liver disease on staff, patients will continue to receive expert, coordinated care closer to home, reducing the need to travel outside the region for evaluation and treatment.

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15th Annual Gulf Coast Trauma Symposium draws healthcare professionals

[https://www.usahealthsystem.com/news/15th-gulf-coast-trauma-symposium-recap]

Jon D. Simmons, M.D., chief of trauma for USA Health, said concentrating on disaster preparedness was one of his goals for the symposium. “It is just always good to try and predict the types of mass casualty incidents that may occur in our region and make sure we’re all on the same page in case that disaster does occur.”

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GENERAL NEWS [HTTPS://WWW.USAHEALTHSYSTEM.COM/NEWS?CATEGORY=GENERAL-NEWS]

Crawford-Meeks accepted into advanced training for chaplain educators and supervisors

[https://www.usahealthsystem.com/news/crawford-meeks-accepted-training-for-chaplain-educators-supervisors]

As an advanced level of Clinical Pastoral Education, the Supervisor-Educator program focuses on preparing chaplains to teach, mentor, and evaluate future CPE students in healthcare and community settings.

Posted 6 days ago

Read Story > [https://www.usahealthsystem.com/news/crawford-meeks-accepted-training-for-chaplain-educators-supervisors]

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Exhibit 4

BECKER'S HOSPITAL REVIEW

Financial Management

CommonSpirit, Cigna reach agreement for Tennessee, Georgia

By: **Jakob Emerson** and **Elizabeth Casolo** Friday, April 3rd, 2026

CommonSpirit Health's Tennessee and Georgia facilities (formerly CHI Memorial), is back in network with Cigna Healthcare, according to an insurer statement shared with *Becker's* April 3.

"We have reached an agreement that will keep CommonSpirit in our network. We look forward to continuing our work with CommonSpirit to improve the health and vitality of our customers in Tennessee and North Georgia," the statement said.

The area's CommonSpirit facilities include three hospitals: Memorial Hospital in Chattanooga, Memorial Hospital – Hixson (Tenn.), and Memorial Hospital – North Georgia (Ringgold). The Chattanooga Heart Institute and more than 650 physicians with the health system's medical group will remain in network, as well.

CommonSpirit also operates 65 care sites and two outpatient imaging centers in Southeast Tennessee and North Georgia.

On Feb. 1, the facilities went out of network for individuals in Cigna's commercial Open Access Plus PPO and its narrower-network Local Plus plan.

This story was last updated April 3.

At the Becker's 11th Annual Health IT + Digital Health + RCM Conference, taking place September 14–17 in Chicago, healthcare executives and digital leaders from across the country will come together to explore how AI, interoperability, cybersecurity, and revenue cycle innovation are transforming care delivery, strengthening financial performance, and driving the next era of digital health. Apply for complimentary registration now.

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By: **Paige Twenter** Monday, March 9th, 2026

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BECKER'S HOSPITAL REVIEW

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Exhibit 5

BUSINESS

UNC Health-Cigna talks fail, leaving over 65,000 patients without in-network coverage

By **Chantal Allam**

Updated December 1, 2025 12:38 PM | Gift Article

An ongoing contract dispute between UNC Health and major insurer Cigna has resulted in thousands of patients losing in-network coverage on Dec. 1. Contributed *UNC Health*

The breakdown of contract negotiations between UNC Health and Cigna has left tens of thousands of patients without in-network insurance coverage.

Starting Monday, Dec. 1, UNC Health hospitals, clinics and providers are “out of network” for Cigna members, meaning it will cost more to use them, said UNC Health spokesperson Alan M. Wolf.

The lapse comes after UNC Health’s three-year contract with Cigna expired on Nov. 30. Days before the deadline, the system warned about 65,000 Cigna members that talks had stalled and coverage would “most likely” be disrupted.

UNC Health said it remains committed to continuing negotiations, but a new agreement must “be consistent with our relationships with other insurance plans,” Wolf said.

Some patients, such as those who are hospitalized, pregnant or undergoing an active course of treatment before Dec. 1, may qualify for “continuity of care” through Cigna for a limited time.

“Patients must contact Cigna directly to determine eligibility and submit the required forms,” Wolf said.

In recent months, Cigna said UNC Health demanded a roughly 32% rate increase over three years. It also accused UNC Health of “stoking fear with our shared patients” as a negotiating tactic.

On Monday, the company said it had offered to extend the current contract and remains “engaged in discussions.”

“The goal is to keep UNC Health in network,” a Cigna Healthcare spokesperson told The N&O in an email.

As of Jan. 1, 2026, UNC Health will be out-of-network with Humana, WellCare, and Health Care Service Corp. (HCSC/formerly Cigna) Medicare Advantage plans, according to its website.

Humana North Carolina State Employee Health Benefit Plan (Medicare Advantage for retirees) members will continue to be seen with no increase in cost.

Meanwhile, Cigna’s open enrollment started Nov. 1 and runs until Dec. 15. It’s the annual period when individuals can enroll in a health insurance plan, switch plans, or apply for premium subsidies.

A growing trend

UNC Health’s dispute with Cigna is part of a broader Triangle trend where hospital–insurer contract breakdowns threaten patients’ in-network access.

In April 2024, a parallel dispute unfolded between UNC Health and UnitedHealthcare, but they reached a last-minute, long-term agreement that kept UNC Health hospitals and clinics in-network for UnitedHealthcare patients.

More recently, a conflict between WakeMed and UnitedHealthcare failed to reach a deal by deadline. WakeMed is now officially out of network with UnitedHealthcare for most patients as of Nov. 15, 2025, according to its website.

They're no longer covered at WakeMed's hospitals, specialty providers, and facilities under UnitedHealthcare's commercial and Medicare Advantage plans.

Editor's note: Are you a patient affected by the coverage lapse? Share your story with The N&O. Write me at callam@newsobserver.com.

This story was originally published December 1, 2025 at 12:05 PM.

Exhibit 6

Updated December 11, 2025

An update regarding our negotiation with Northeast Georgia Health System

More than 30 months have passed since Northeast Georgia Health System (NGHS) left our network following its demands to be paid significantly more than any health system in Georgia. We are writing today to share an update regarding our efforts to reach an agreement that's affordable for Georgia families and employers.

We delivered a proposal to NGHS on Nov. 10 as part of good-faith efforts to move our negotiation forward. Rather than finalizing the terms of our proposal or providing a counter, NGHS has instead informed us that our negotiation is not a current priority.

The last proposal we received from NGHS would make it significantly higher cost than any other hospital in the state. Consider the following:

- NGHS' demands would make it 34% more expensive than the average cost of the other hospitals ranked in the top 10 of **U.S. News & World Report's rankings for top hospitals in Georgia**.
- NGHS' hospitals would be more than 20% higher cost than the next-most expensive hospital in the state.

Rather than working with us to reach an agreement that's affordable for Georgians, NGHS is seeking higher price hikes now than at any point during our negotiation.

Since going out of network, NGHS has more than tripled its prior rate demands for its physicians. NGHS' latest proposal represents a more than 50% price hike on average for all of its physicians in the first year of our contract, and would make them significantly higher cost than all other physician groups in our network in the state. This includes demands for a 115% price hike for Longstreet Clinic – which NGHS recently announced it is acquiring – and has since issued a notice to end our network relationship, effective March 4, 2026.

This is yet another example of how NGHS has used its market dominance to acquire providers and drive up health care costs for consumers and local companies at an unsustainable rate.

We are committed to continued good-faith negotiation. However, we need NGHS to join us at the negotiating table and provide a realistic proposal Georgia families and employers can afford.

Standing firm against unaffordable price hikes

It remains our top priority to reach an agreement with NGHS that restores network access to the health system at costs that are affordable for Georgians and employers. We have made meaningful movement and compromises in each of our proposals as part of good-faith negotiation designed to reach an agreement. All of our proposals would ensure NGHS is reimbursed at rates that are more than fair and reasonable.

Unfortunately, minimal progress has been made in the nearly eight months since NGHS chose to leave our network. NGHS' latest proposal actually moved our organizations farther apart. NGHS is seeking an approximate 25% price hike that would take effect over the first 24 months of our contract, including demands for a near 14% rate increase in year one that would make its hospitals the most expensive in Georgia.

NGHS is also demanding that we make the contract retroactive to May 1, which would lead to a significant amount of money coming from the operating budgets of employers who would be unexpectedly hit with additional costs.

Please know we do not take this disruption in the market lightly and remain fully committed to continued good-faith negotiation with NGHS. However, NGHS must join us at the negotiating table and work to find a reasonable solution Georgians and employers can afford rather than repeating its demands for unsustainable price hikes.

Information for our members

Please note: NGHS has stated on its website that people enrolled in the UnitedHealthcare Group Medicare Advantage National PPO plan, including the Medicare Advantage State Health Benefit Plan for retirees, are not impacted by this negotiation. People enrolled in this plan will continue to have access to NGHS' hospitals and physicians.

NGHS is demanding a near 25% price hike over that would take effect over the next 24 months, including a double-digit rate increase in the first year that would make its hospitals the most expensive in Georgia.

NGHS' demands are not affordable or sustainable and would drive up premiums and out-of-pocket costs for Georgians as well as the cost of doing business for both self-insured and fully insured companies, impacting their ability to offer health care coverage for their employees.

Cost information specific to our self-funded customers.

Agreeing to NGHS' demands would mean one of our self-funded customers would see their health care costs increase by more than $3.5 million, while several others would see increases of more than $380,000 to nearly $540,000 over the next three years.

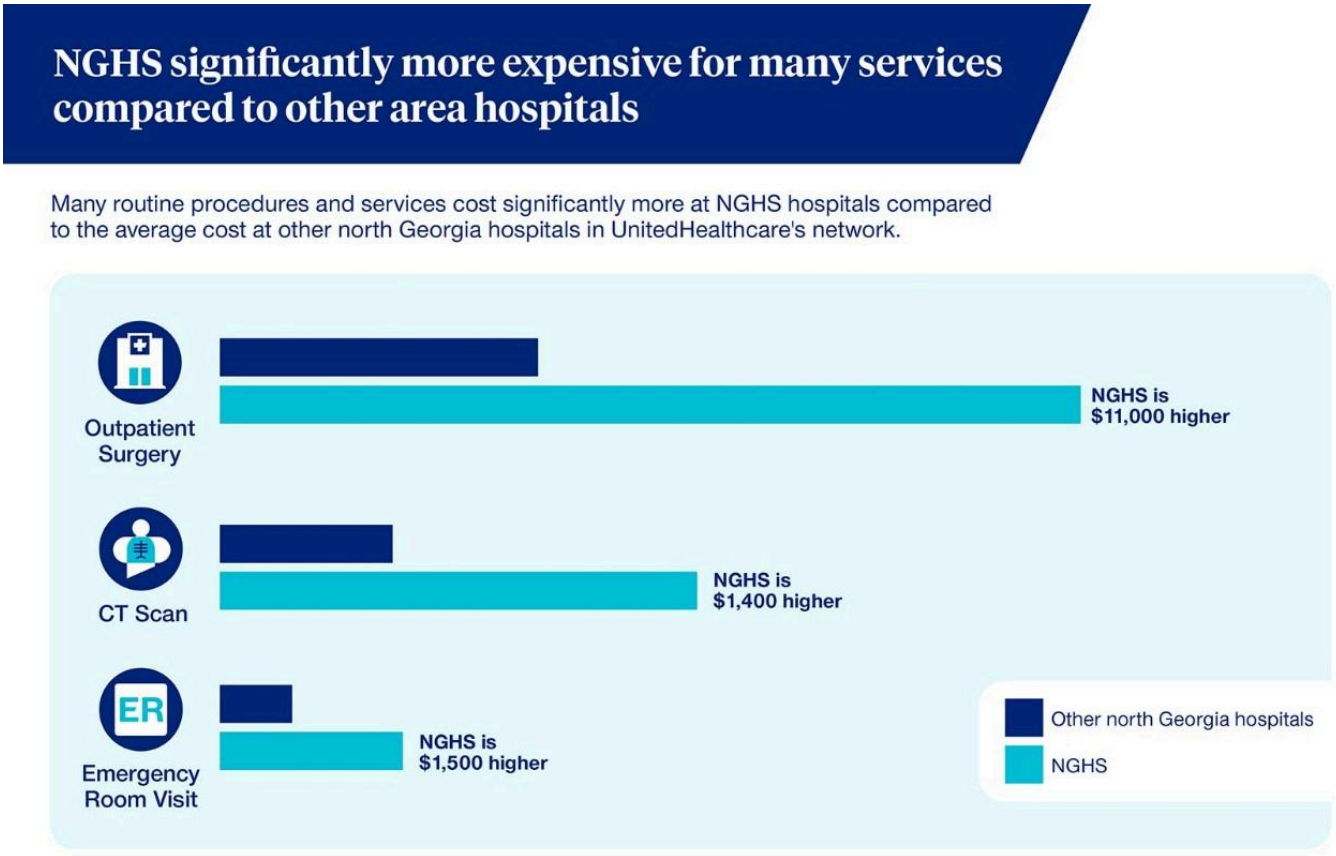
NGHS' rate demands would directly drive up health care costs for our self-insured customers given that these employers pay the cost of their employees' medical bills themselves rather than relying on UnitedHealthcare to pay those claims. In Georgia, more than 70% of our commercial members are enrolled in self-insured plans.

NGHS' proposal for egregious price hikes when its hospitals are already charging exorbitantly high rates would impact many businesses' ability to continue offering affordable health care coverage for their employees. It would also mean they have less money available to pay competitive wages and to help grow the business through things like investments in new technologies.

The cost of care at NGHS' hospitals is 47% higher than the average cost of hospitals in our network throughout northern Georgia. NGHS is also an outlier when compared to hospitals throughout the state.

The cost of a surgery at NGHS is **29% higher** than the state average, while radiology services are **35% more expensive** at NGHS compared to the state average of hospitals participating in our network.

NGHS charges egregiously high rates even for common services, tests and surgeries when compared to its peers. Consider the following examples:



- The cost of an MRI at an NGHS hospital is **2 ½ times higher** – or **approximately $1,600 more** – than it would cost on average to receive the same test at another hospital participating in our network in north Georgia.
- The cost to receive a CT scan at NGHS is nearly **$1,400 more** than the average cost at other hospitals throughout north Georgia.

- The average cost of an outpatient surgery at an NGHS hospital is **nearly $11,000 more** than the average cost at peer hospitals throughout north Georgia.
- The cost of an emergency room visit at NGHS is approximately **$1,500 more** – or **65% higher** – when compared to the cost at hospitals in north Georgia, and **42% higher** when compared to the state average.

We remain committed to good-faith negotiation with the goal of reaching an agreement that is affordable for the Georgians and employers we serve

We know many people have developed personal relationships with their NGHS physician, value having access to the health system and are rightfully concerned by this news. Please know we remain committed to continued discussions with NGHS. However, we need the health system to join us at the negotiating table and work with us to find a solution that is affordable for the businesses and people we serve.

Exhibit 7

Prepared by the Court

ATLANTIC ER PHYSICIANS, PA, *et al*	:	Superior Court of New Jersey
Plaintiff	:	Law Division- Gloucester County
v.	:	
	:	CIVIL ACTION
UNITEDHEALTH GROUP, INC.,	:	Docket No. GLO-L-1196-20 (CBLP)
UNITEDHEALTHCARE INS. CO., *et al*	:	
And MULTIPLAN, INC.	:	**Memorandum of Decision**
Defendants	:	

These motions to dismiss under R. 4:6-2(e), arise from an action filed by plaintiffs, “NJ Team Health”, who are emergency room physicians groups from all over the State who generally complain about out-of-network reimbursement rates from the defendants, who are health insurers and third-party administrators of employee health benefit plans.

More specifically, Team Health is a large emergency room staffing, billing and collections company that operates throughout the United States. They provide outsourced emergency medicine services on a national scale, and operate as many as 3,400 emergency medical facilities, employing approximately 19,000 people. Defendants are health insurers and third-party administrators who operate the largest health insurance carrier in the United States. These are primarily employee health benefit plans. Most healthcare providers enter into agreements (“network agreements”)

with health insurers and third-party administrators which specify how much the health plan will reimburse the provider for medical services rendered to their covered insureds. Healthcare services provided without any contractual agreement specifying a providers' reimbursement rates are "out-of-network", and the benefit amount is governed by the applicable heath benefit plan of which the patient is enrolled.

With regard to the instant action, until May 2020, Team Health plaintiffs allege their relationship with the defendant was controlled by a written contract in which they agreed to accept a certain negotiated amount for the health care services they provided to the defendants' insureds. It is alleged that around 2018, the United defendants unilaterally decided to substantially reduce reimbursement rates for plaintiffs' out-of-network services. In May 2020, United began implementing that plan against plaintiffs by terminating the express written agreements between the parties and thereafter began paying substantially less than what was previously agreed and substantially less than the reasonable value of the services plaintiffs provide. After May 2020, defendants contracted with defendant, Multiplan, Inc. to determine this out-of-network payment. Multiplan promotes itself as an unregulated cost management company that offers "cost control" through a program known as Data iSight. Multiplan claims the Data iSight program determines a reasonable reimbursement rate for health care services by applying a proprietary formula to the submitted claims. It is alleged that Multiplan receives a share of the fees an insurance company earns from adjudicating a health care provider's claim for less than the amount the provider charged.

This case involves 27,000 disputed claims for emergency services provided by plaintiffs to United members during the period from May 15, 2020, to December 31,

2021. As emergency medicine providers, the plaintiffs are required by law to treat and stabilize patients who present to the emergency room regardless of insurance coverage. The plaintiffs rely upon commercial insurance companies to pay a reasonable rate for the critical health care services provided. Plaintiffs allege that United and Multiplan conspired together to deny plaintiffs their billed amounts for medical services relying upon Multiplan's payment methodology. Plaintiffs contend that Multiplan's publicly stated claims process is based upon rational and accepted data is a fraud. Plaintiffs insist that United dictates the rates to be paid and uses Multiplan as a cover for this fraud. Plaintiffs contend that United and Multiplan reap huge profits at the expense of the plaintiffs. Plaintiff are suing to recover the reasonable value of their services over what was paid on these 27,000 claims. The plaintiffs' Second Amended Complaint sues the defendants alleging five separate causes of action- Count One- Breach of Implied-in Fact Contract; Count Two- Quantum Meruit; Count Three- Violation of New Jersey Health Claims Authorization, Processing and Payment Act ("HCPPA") (the first three counts are directed to defendants United, only); Counts Four and Five allege RICO violations and conspiracies as to both defendants. This similar litigation has been advanced in 6 or 7 other states to date.

STANDARD OF REVIEW

Under R. 4:6-2(e), a motion to dismiss for failure to state a claim must be denied if, giving plaintiff the benefit of all the allegations asserted in the pleadings and all favorable inferences, a claim has been established. Grillo v. State, 469 N.J. Super. 267 (App. Div. 2021). The test for determining the adequacy of the pleading is whether a

cause of action is suggested by the facts. Motions to dismiss should be granted in only the rarest of instances. *See,* Printing Mart v. Sharp Elec. Corp., 116 N.J. 739 (1989).

ERISA PREEMPTION

This matter was originally filed on November 2, 2020, and defendants removed to the United States District Court, District of New Jersey. On February 17, 2021, plaintiffs filed a motion to remand this lawsuit from the District Court. On March 30, 2022, United States District Court Judge Renee Marie Bumb entered an Order that states in pertinent part, "unless and until there is clearly established precedent, if United Defendants argue for federal subject matter jurisdiction in the future based upon ERISA preemption, they must disclose to the court the caselaw that cuts against their legal arguments. United Defendants should lay out that federal district courts in New Jersey, Pennsylvania, Nevada, Arizona, Florida and perhaps elsewhere have denied their arguments for ERISA preemption." When pressed at oral argument, plaintiffs' counsel conceded that no court has found ERISA preemption in this matter.

ERISA was passed by Congress in 1974 to address "mismanagement of funds accumulated to finance employee benefits. ERISA does not guarantee benefits. The statute seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures. Gobeille v. Liberty Mut. Ins. Co., 136 S.Ct. 936, 946 (2016). ERISA was created to ensure employee benefit plans would be subject to a uniform nationwide regulatory scheme, and not a patchwork of inconsistent state regulations. To that end, ERISA includes "expansive pre-emption

provisions" to ensure that the regulation of employee benefit plans remain "exclusively a federal concern". Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). There are two preemption types. Complete preemption under Section 1132(a), which is jurisdictional in nature. This preemption was rejected by Judge Bumb. The other form of preemption is conflict preemption under Section 514(a). this section expressly preempts state action and state law claims that "relate to" an ERISA plan. United Defendants argue that plaintiffs' claims relate to ERISA-governed health benefit plans and therefore must be dismissed with prejudice as conflict preempted.

A common law claim "relates to" an employee benefit plan governed by ERISA "if it has a connection with or reference to such a plan". Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004). At this stage of the proceeding, the court finds that plaintiffs' state law claims relate solely to the rate of reimbursement, not the right of reimbursement. Each of the 27,000 claims at issue here have been paid by the defendants. Plaintiffs are not disputing the right to coverage under the plan rather they plead that the United defendants did not pay the reasonable value of the emergency services or they were underpaid for these services. Plaintiffs cite the U.S. Supreme Court case of Rutledge v. Pharm. Care Mgmt. Ass'n, 141 S.Ct. 474 (2020) as support for their position. As stated therein, "[C]rucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." Id. at 480. Continuing, the Court says "ERISA does not preempt state rate regulations that merely increase costs..". At this stage, the court finds plaintiffs' arguments persuasive. As plaintiffs' state in their brief, they seek to hold United to its

obligation to pay a reasonable value for the benefits United has already agreed to pay out. Plaintiff allegations do not implicate coverage determinations or plan administration requirements. Plaintiffs allege that they are entitled to the "reasonable value" of their services under applicable state law- not an ERISA plan. ERISA's goals of protecting participants and beneficiaries of employee benefits plans are not altered by plaintiffs claims.

Defendants request to dismiss for 514(a) preemption is denied.

DEFENDANTS CLAIM THAT PLAINTIFF CASE SHOULD BE DISMISSED BY THE ARBITRATION PROCESS ENACTED IN N.J.S. 26:2SS-1

In 2018, the New Jersey Legislature passed the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "Act"). Defendants claim that plaintiffs must arbitrate any claims decision at issue in this case under the process outlined in Sections 9,10 and 11 of the Act. This argument is without merit. The Act's definitions under Section 3 specifically exclude self-funded plans unless the self-funded plan elects to be subject to the provisions of the Act. United defendants claim they are self-funded plans in their argument regarding preemption and have not provided any proof that they have opted-in to this statutory scheme. This basis alone precludes dismissal of plaintiffs' complaint.

COUNT ONE- BREACH OF IMPLIED-IN-FACT CONTRACT

United defendants seek dismissal of Count One of the Second Amended Complaint that alleges breach of an implied-in-fact contract. Plaintiffs' complaint alleges that prior to May 2020, the parties had a written contract for the reimbursement rates to be paid for out-of-network emergency health care services. They allege in paragraph 3 that in 2017 to 2018, "United concluded it could make more money by paying Plaintiffs and other emergency room doctors less, so United embarked on a scheme to do just that." In paragraph 28 through 31, it is alleged that United terminated the express written agreement in place to pursue greater profits by substantially reducing reimbursement rates it provided plaintiffs. The complaint says that United cut reimbursement rates to less than half what United had paid in the past pursuant to its previous contract. The plaintiffs now sue for recovery of the difference between what they bill versus what they were paid.

The essential feature of an implied-in-fact contract cause of action is that the asserted contractual obligation must have arisen from mutual agreement and intent to promise but where no written agreement is in place. However, the facts as pleaded decisively refute the existence of such agreement. To prevail on a breach of contract action, whether written or implied, a plaintiff must be able to prove all of the necessary terms of the contract. Here, the Second Amended Complaint could not be clearer that the parties were not in agreement as benefit amount the defendants would pay for the plaintiffs' services. Plaintiffs want the amount billed, as they contend it is a reasonable amount as to the value of their services. Defendants, however, paid a different amount- an amount they say is appropriate according to the Data iSight methodology. This

essential term- price is in no way an agreed upon term in this implied contract. Certainly, the court agrees that many of the other factors are in place, i.e. the agreement to provide out-of-network emergency services to the plan members and the expectation that the providers would be paid. But price is the element that does not exist in this arrangement. Plaintiffs specifically plead defendants terminated the contract in place prior to May 2020 because defendants did not want to pay the agreed upon rates. This undermines this cause of action.

Count One of plaintiffs' complaint is dismissed for failing to state a cause of action as plead.

COUNT TWO- QUANTUM MERUIT

In order to recover on a claim for the quasi-contractual theory of quantum meruit, a plaintiff must establish four elements: (1) the performance of services in good faith; (2) the acceptance of services by the person to whom they are rendered; (3) an expectation of compensation therefore; and (4) the reasonable value of the services. Sean Wood LLC v. Hegarty Group, 422 N.J. Super. 500, 513 (App. Div. 2011). "Quasi-contractual recovery on the basis of quantum meruit rests on the equitable principle that a person shall not be allowed to enrich himself unjustly at the expense of another" Id. at 512.

In order for plaintiffs to sufficiently plead this cause of action, it must demonstrate that the services they performed in good faith conferred a benefit not only on the patients they served (who are not defendants) but rather on the insurers of the patients. The complaint alleges in paragraph 59 that "[B]oth United and United's Members benefited from the services Plaintiff provided. For example, United used and enjoyed the benefit of Plaintiff's services because Plaintiffs help United discharge its

legal and contractual obligation to its insureds to provide them with emergency care". At this stage of the proceedings, this argument is persuasive. The insurer defendants received a benefit by paying the plaintiffs a rate of reimbursement significantly less than a reasonable rate. They were able to pocket the difference in profits while simultaneously discharging its contractual obligation to pay for out-of-network emergency care for its members. Though the benefit conferred is not direct, there is arguably a benefit conferred to the defendants.

COUNT THREE- VIOLATION OF NEW JERSEY HEALTH CLAIMS AUTORIZATION, PROCESSING AND PAYMENT ACT ("HCAPPA")

Team Health plaintiffs allege in Count Three that the defendants failed "to timely pay the full amounts due to plaintiffs for their out-of-network emergency claims", in violation of HCAPPA, N.J.S. 17B:26-9.1. This statute permits the provider from recovering 12% interest on any unpaid claims. The parties go back and forth on whether the statute confers a private right of action by a medical provider against an insured. At this point, the court does not have to reach this answer. This statutory penalty for failing to pay a valid insurance claim promptly is only applicable if plaintiff is successful in this litigation compelling payment from the defendants. The court will revisit this issue upon a successful recovery by plaintiff.

COUNTS FOUR AND FIVE- VIOLATIONS OF NJ-RICO (as to both sets of defendants)

In Counts Four and Five of the Second Amended Complaint, plaintiffs allege that the defendants committed acts of theft under N.J.S. 2C:20-3(a) and (b), 2C:20-4(a)-(c) and 2C:20-8(a) by a pattern of racketeering activity in violation of N.J.S. 2C:41-1.

Basically, the plaintiffs state that United and Multiplan engaged in a conspiracy to divert millions of dollars away from the plaintiffs by falsely and fraudulently hiding behind Data iSight methodology, which in fact was a deceitful ploy to pay reimbursement rates set by United rather than reasonable value.

To state a claim for violation of New Jersey's RICO law (N.J.S. 2C:41-1, et seq.), a plaintiff must allege (1) the existence of an enterprise; (2) that the enterprise engaged in activities that affected trade or commerce; (3) that the defendants were employed by or associated with the enterprise; (4) that the defendants participated in the conduct of the affairs of the enterprise; (5) that the defendants participated through a pattern of racketeering activity; and (6) that the plaintiff was injured as a result of the activity. Marina Dist. Dev. Co. v. Ivey, 216 F. Supp. 3d 426, 436 (N.J. Dist. Ct. 2016). A defendant in a racketeering conspiracy need not itself commit or agree to commit predicate acts. Smith v. Berg, 247 F.3d 532, 537 (3d Cir. 2001). Rather, "all that is necessary for such a conspiracy is that the conspirators share a common purpose." Id. Thus, if defendants agree to a plan wherein some conspirators will commit crimes and others will provide support, "the supporters are as guilty as the perpetrators." Salinas v. United States, 522 U.S. 52, 64, 118 S. Ct. 469, 139 L. Ed. 2d 352 (1997). Each defendant must "agree to commission of two or more racketeering acts," United States v. Phillips, 874 F.2d 123, 127 n.4 (3d Cir. 1989), and each defendant must "adopt the goal of furthering or facilitating the criminal endeavor," Smith, 247 F.3d at 537.

Defendants first argue that plaintiff's pleading is deficient in that it does not comply with the heightened pleading standard required by R. 4:5-8. This rule requires "[I]n all allegations of misrepresentation, fraud, …. Particulars of the wrong, with dates and items *if necessary*, shall be stated *insofar as practicable.* (emphasis supplied). Here, the complaint satisfies the Rule by placing defendants on notice of the alleged wrongs. Specifically, the complaint states that between May 2020 and December 2021, United Healthcare defendants conspired with Multiplan defendant to unilaterally set the rate of reimbursement for the plaintiffs. This rate was set by United but asserts fraudulently that the reimbursement rate was determined by Data iSight at a geographically competitive rate. The fraud/conspiracy began just before the May 2020 change. The plaintiff alleges damages calculated at the amount billed by plaintiff minus the amount paid by defendants. This pleading is sufficient as to R. 4:5-8.

The more interesting argument raised by both defendants is that plaintiffs fail to allege that the defendants' racketeering conduct was the proximate cause of their damages. See, Maio v. Aetna Inc., 221 F.3d 472, 483 holding that plaintiff must "make two related but analytically distinct threshold showings…(1) that the plaintiff suffered an injury to business or property; and (2) that the plaintiff's injury was proximately caused by the defendants' [RICO] violation. The defendants argue that plaintiffs are required to treat all patients who arrive at hospitals for emergency care, and even if the defendants shared their payment methodology, nothing would change, i.e. the plaintiffs would receive the same amount. This court finds this unpersuasive as the argument ignores the alleged fraud as alleged. Plaintiffs say that the Data iSight rate is merely a cover for

United's reimbursement rate that it unilaterally set. The plaintiffs allege that United and Multiplan conspired to set an artificially low rate to reap huge profits disguising its conspiracy by pretending the rate was set by Data iSight. Their damages would be the difference between they amount they billed and the amount they received. As alleged, the plaintiff's damages are the proximate cause of the RICO conspiracy. They may has performed the same services as required by law, but they would have received significantly more money for doing so, if not defrauded by the defendants.

The court requests the defendants prepare an Order consistent with this opinion.

DATED: August 23, 2022

_____
JAMES R. SWIFT, JSC

Exhibit 8

Advocating for you

Memorial Healthcare System chose to go out-of-network as of September 1, 2025 — Florida Blue is continuing to negotiate for you

We understand how upsetting this situation has been for individuals, families, and businesses in Broward

County, and our goal is for Memorial Healthcare System to rejoin our network as soon as possible.

We want to keep you informed about our **ongoing negotiation efforts** with Memorial Healthcare System (Memorial), **what it means for you**, and **how we are here to support you** given Memorial's decision to leave our network.

We know individuals and families are frustrated by the increasing cost of living, the rising cost of health care, and with having this trusted local health system out of network.

We welcome any opportunity to advance discussions towards a reasonable and sustainable resolution.

We're disappointed that Memorial Healthcare System has chosen to remain out of network for an extended period, though it's our duty as a mission-driven company to advocate for our members and the community, prioritizing their care and financial well-being.

Important updates

As of March 1, 2026, Nicklaus Children's Health System (Nicklaus) has expanded its reach, now offering acute inpatient and outpatient children's services at two Broward County hospitals.

- Broward Health Medical Center (main campus), 1600 S. Andrews Ave., Fort Lauderdale, FL 33316
- Broward Health Coral Springs, 3000 Coral Hills Dr., Coral Springs, FL 33065

As we work to resolve this matter, this means thousands of our members now have added convenience and additional in-network access to pediatric care.

Nicklaus Children's also offers pediatric urgent care, specialists, and diagnostics at locations throughout Broward County, including:
Cooper City, Coral Springs, Weston, Davie, Fort Lauderdale, Miramar, Pembroke Pines, Pompano Beach y West Pembroke Pines.

Negotiating with hospital systems is a regular part of our business. For months we have been in discussions with the executive leadership team at Memorial Healthcare System to try and have their hospitals, emergency rooms, physicians, and other facilities and clinicians back in our network of participating providers.

Unfortunately, Memorial Healthcare System continues to demand unreasonable rates that will drive up the cost of health care for many in Broward County — and, **as of September 1, 2025, they became an out-of-network provider.**

- We continue to have regular discussions with their leadership team and welcome any opportunity to advance discussions towards a reasonable and sustainable resolution.
- We've made efforts to bridge the gap and resolve outstanding issues, and continue to emphasize that collaboration and compromise from both sides, prioritizing patients, will help us reach the finish line.
- We continue urging Memorial Healthcare System executives to reach a reasonable solution that works for everyone.
- We are supporting members who are impacted by this change, including those who get care through Broward Health.
- We have many high-quality local hospitals and doctors in the area ready to take care of our members' care needs.
- Memorial Healthcare System's unreasonably high rate-demands would dramatically increase the cost of care for people in Broward County.
- With your health care costs directly affected by the rates we negotiate; it is our responsibility to protect members from unnecessary increases.
- Especially during these difficult economic times, we want to work with Memorial Healthcare System on a solution that works for everyone — without placing an undue burden on hard-working families, small businesses, and individuals already struggling to make ends meet.

Working on your behalf

We've been negotiating in good faith from the start and will continue working to negotiate reasonable rates with Memorial Healthcare System.

Memorial Healthcare System is **mission-driven** and a cornerstone of health care in South Florida. We value our longstanding partnership **and appreciate the care they provide for some of our community's most vulnerable.**

We know how important your relationship with your care team is, and our focus is protecting that relationship. Unfortunately, Memorial Healthcare System has not backed off their demands for unreasonable and excessive rate increases which jeopardize how much you'll pay and how you access care.

- **Memorial Healthcare System wants an excessive rate increase that would lead to higher health care costs for Florida Blue members, especially during this time of economic strain.**
    - It would be unfair to members to agree to their current demands which would raise how much you pay for services at Memorial, drive up your health insurance each month, and make health

care even less affordable.

- **In addition to the concerns about their rate demands, we are also asking Memorial for more transparency and predictability in what patients are charged, to avoid large "surprise bills" for individuals, families, and employer groups.**
    - During their current contract, Memorial Healthcare System has made a practice of increasing charges in a way that far exceeds standards. For example, their charges for cancer-fighting chemotherapy have skyrocketed over the past 4 years, resulting in a **150% increase** in the average cost of a single course of treatment.

A history of collaboration

Throughout our decades-long collaborations with Memorial Healthcare System, despite the complexities of these negotiations, we've consistently prioritized patient needs and worked together to achieve an outcome that works for everyone.

That's our goal in this negotiation: a sensible and sustainable solution.

What's at stake

Florida Blue members: it's your money on the line. Especially during these challenging economic times, large rate increases and higher-than-expected costs are not sustainable and would create more uncertainty and financial strain for our members and the communities we serve.

When health care hospital systems charge more, it raises costs for everyone with higher premiums, copays, and out-of-pocket costs. Our job is to advocate for our customers during these discussions with providers.

Negotiations between insurers and hospitals can be unsettling for members whose access to care may be impacted.

Our priority is your access to quality health care that is as affordable as possible.

About Memorial Healthcare System

Memorial Healthcare System is a trusted part of our community's health care landscape. They are a mission-driven safety-net health system, which means they are essential to the community, providing care to the area's most vulnerable and underserved populations.

We want a new agreement that works for everyone and allows us to continue our commitment to the communities we collectively serve.

Facts you should know

- The cost of health care is a significant challenge for many families and individuals.
    - In fact, according to a Gallup poll, 11% (equivalent to nearly 29 million people) of people said they could not afford medication and care within the past three months, the highest level in the four years the survey has been conducted.
- We understand the challenges facing hospitals and providers, though the current economic conditions and financial pressures are not unique to Memorial Healthcare System.
- The issue is **not** with the doctors, nurses, or medical team of health care professionals who take care of you and our community's well-being.
- Memorial Healthcare System's executive leadership wants a significant increase in its prices, and that comes right out of your paycheck. That's why we're continuing to work on an agreement with reasonable prices.
- The leaders from Memorial Healthcare System entered the commercial insurance business for 2026 with an individual Marketplace insurance product — while demanding significant rate increases for our low-cost individual Marketplace health plan, myBlue, in which Memorial has participated since 2016. It is unfair for the leaders at Memorial to expect Florida Blue to subsidize their new commercial insurance business venture through their demand for excessive rate increases. Agreeing to their demands would drive up the cost of health care, and it's the most vulnerable who'll suffer most.
- We continue to offer them sustainable, sensible, and fair market rate increases that balance the community's needs, our members' concerns, and the economic realities facing hospitals and all of us in health care.
- The community should not have to pay more than what's reasonable through their monthly premiums and out-of-pocket costs.

Protecting YOU is our priority

We're on your side, advocating for individuals, families, businesses, and seniors — to protect our members and the community from the burden of unnecessary and substantial increases in health care costs and to keep you connected to trusted local doctors and hospitals.

The primary responsibility of health insurance plans is ensuring members have access to high-quality **AND** affordable health care. That mission has never been more important than now, when costs continue rising, and the public is counting on us to act.

Continuation of Care

Since we were unable to reach an agreement with Memorial Healthcare System before the current contract deadline, its hospitals, emergency rooms, physicians, and other clinicians and its many service locations are no longer be in our provider networks as of September 1, 2025.

As of March 1, 2026, two Memorial Ambulatory Surgical Centers (ASCs) are back in-network with Florida Blue:

- Cypress Creek Outpatient Surgical Center, 2122 W. Cypress Creek Rd., Suite 120, Fort Lauderdale, FL 33309
- South Broward Endoscopy LLC, 11011 Sheridan Street, Suite 106, Hollywood, FL 33026

Even though they're no longer in-network, some members have been eligible to continue getting care from their current Memorial Healthcare System provider or facility.

There are state and federal protections called Continuity of Care, that immediately take effect for a specified period, if an agreement is not reached. This protects coverage for pregnant mothers and others undergoing active treatment care for serious and complex conditions, or in post-operative care following surgery, etc. So, eligible members can continue to get care from their providers at the same in-network rates and member responsibilities as required by applicable law.

Frequently asked questions

About the negotiation

- When exactly does the contract with Memorial Healthcare System Health end?
- Which hospitals/doctors/locations/facilities are out-of-network starting September 1, 2025?
- Are both parties still negotiating?
- Why is this happening? Can you tell me more about the negotiations?
- Can you tell me more about Memorial Healthcare System?
- Why doesn't Florida Blue just pay the rate asked?
- How do I know if this negotiation impacts my current provider?

What's next?

- I received a letter that my provider will be out-of-network. What happens now?
- What if I am currently receiving care and my Memorial Healthcare System provider becomes out-of-network?
- How do I find a new provider?
- What about emergencies (the ER)?
- What happens if an ER visit results in a hospital admission (and the hospital is no longer in the network)?

What if I am pregnant?

About the provider network

What are my options? Do you have a large enough network of providers in my area?

What is a network?

What do “in-network” and “out-of-network” mean?

About health care costs

If you’re negotiating for a better rate, why are health care costs still so high?

Are you doing anything to take on the factors that drive up costs?

How does Florida Blue spend my premium dollars?

To learn more

Where can I learn more about Florida Blue’s contract negotiations with providers?

What if I have a specific question about how these negotiations are going?

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FBC MEGA NF 012026

Exhibit 9

IN THE SUPERIOR COURT OF HALL COUNTY
STATE OF GEORGIA

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM, LLC,	
Petitioner,	
v.	**Case No.: 2024CV000529**
UNITED HEALTHCARE OF GEORGIA, INC.,	
Respondent.	

ORDER

The above-styled case is before this Court on Petitioner's Motion for Summary Judgment. Having considered the pleadings filed by each party, and receiving no request for oral argument, the Court enters the following Order:

Summary judgment is appropriate when there is no genuine issue of material fact and the undisputed facts, viewed in the light most favorable to the nonmoving party, warrant judgment as a matter of law. O.C.G.A. § 9-11-56(e); *Lau 's Corp. v. Haskins*, 261 Ga. 491,491,405 S.E.2d 474, 475 (1991). When a motion for summary judgment is made as provided in O.C.G.A. § 9-11-56, an adverse party may not rest upon the mere allegations or denials of his or her pleadings. Rather, his or her response by affidavits or otherwise must set forth specific facts showing that there is a genuine issue for trial. *Tap Room, Inc. v. Peachtree-TSG Assocs.*, LLC, 270 Ga. App. 90, 93,606 S.E.2d 13, 15-16 (2004); O.C.G.A. § 9-11-56(e).

The matter pending before the Court is a declaratory judgment action to determine whether there is a contractual basis for the rates of fees owed to Petitioner, Northeast Georgia Medical Center Habersham ("NGMC Habersham"), for medical services provided to Respondent United

Healthcare of Georgia's ("UHC") insured clients. NGMC Habersham has operated a hospital in Habersham County since July 1, 2023. Neither NGMC Habersham nor UHC are signatories to any written contract establishing rates for these payments. UHC entered an agreement in 2006, known as the "Facility Participation Agreement." ("FPA"), with Habersham County Medical Center ("HMC"). HMC operated a hospital at the same site as NCMC Habersham prior to July 1, 2023. The present dispute arose when UHC's network manager asserted that the FPA governed rates for services provided by NGMC Habersham. NGMC Habersham contends that there is no governing contract and it is entitled to out-of-network rates for services to UHC insureds. UHC has been paying NGMC Habersham for provided services at the FPA rates.

As an initial matter, the Court will consider UHC's suggestion that there is remaining discovery to be conducted. The Court disagrees. "A party seeking to . . . obtain a declaratory judgment may, at any time after the expiration of 30 days from the commencement of the action . . . move with or without supporting affidavits for a summary judgment in his favor upon all or any part thereof." O.C.G.A. § 9-11-56(a). Further, in general, "desired discovery procedures must . . . be commenced promptly, pursued diligently and completed without unnecessary delay and within 6 months after the filing of the answer." Uniform Superior Court R. 5.1. The Petition was filed on March 29, 2024, and the Answer was filed on June 8, 2024. No discovery was conducted before NGMC Habersham filed this Motion for Summary Judgment on October 4, 2024. The parties agreed to a period of discovery and an extension of time for UHC to respond. Written discovery has been exchanged. UHC has not identified challenges in obtaining specific information that may be needed.

Having determined that no additional discovery period is required before the Motion can be decided, the Court turns to the Motion for Summary Judgment. Summary judgment is

appropriate in declaratory judgment actions seeking a decision of the court interpreting the parties' respective contractual obligations. *E.g. Crosby v. Lebert,* 285 Ga. 297, 676 S.E.2d 192 (2009). "Contract disputes are particularly well suited for adjudication by summary judgment because construction of contracts is ordinarily a matter of law for the court." *Elwell v. Keefe*, 312 Ga. App. 393, 394, 718 S.E.2d 587, 589 (2011); *see also Rounds v. Hall County,* 367 Ga. App. 219, 226, 885 S.E.2d 256, 262-63 (2023).

The instant case is simple and governed by basic principles of contract interpretation. The parties agree that there is no contract between NGMC Habersham and UHC that governs the rates for services. The only contract UHC offers as a basis for the rates is the FPA. The first principle of contract construction is to determine whether the language is clear and unambiguous. *Y.C. Dev. Inc. v. Norton,* 344 Ga. App. 69, 73, 806 S.E.2d 662, 666 (2017). If it is, "no construction is required or even permissible." *Unified Gov't of Athens-Clarke County v. McCrary*, 280 Ga. 901, 903, 635 S.E.2d 150, 152 (2006) (citations omitted). The FPA is between UHC and HMC. NGMC Habersham is not a party to the FPA. It is "fundamental that '[a] person who is not a party to a contract (i.e., is not named in the contract and has not executed it) is not bound by its terms.'" *Plaza Props. v. Prime Bus. Invs.,* 240 Ga. App. 639, 642, 524 S.E.2d 306, 309 (1999) (citation omitted); *see also Primary Investments, LLC v. Wee Tender Care III, Inc.*, 323 Ga. App. 196, 198-99, 746 S.E.2d 823, 826-27 (2013); *Levy v. Reiner*, 290 Ga. App. 471, 473, 659 S.E.2d 848, 851 (2008).

UHC raises three legal grounds to impose the FPA on NGMC Habersham: (1) NGMC Habersham expressly assumed the contract; (2) NGMC Habersham implicitly assumed the contract/waived its ability to challenge rates by accepting payments; and (3) NGMC Habersham is in fact only a "mere continuation of business" operated by Habersham County Hospital

Authority before July 1, 2023. Construing the facts in favor of UHC as the nonmoving party, the Court finds that UHC has not pointed to evidence giving rise to a triable issue of fact on any of these theories.

First, "[a] third person may… assume the [contractual] obligation expressly in writing." *Sims v. Bayside Capital, Inc.*, 327 Ga. App. 47, 53, 755 S.E.2d 520, 525 (2014). UHC does not point to any evidence that NGMC Habersham expressly assumed the FPA in writing. UHC argues that the FPA must have been assumed by NGMC Habersham because the terms of the FPA require HMC to ensure any party purchasing its assets to abide by the terms of the FPA and argues that the FPA was not properly terminated. But NGMC Habersham was not a party to the FPA and was not, therefore, responsible for ensuring the agreement was followed or terminated. UHC argues that NGMC Habersham assumed the contract in the Asset Purchase Agreement through which the Hospital Authority of Hall County and the City of Gainesville acquired the assets of the Hospital from Habersham County Hospital Authority. NGMC Habersham was not a party to that contract either. Further, the Asset Purchase Agreement does not "expressly assume" the obligations in the FPA. The FPA is not listed in the specifically assumed contracts. UHC argues that the Asset Purchase Agreement does not expressly exclude the FPA – but the issue before the Court is whether NGMC Habersham expressly assumed the FPA in writing, and it did not. The communications to UHC by HMC and NGHS in May[1] and June 2023 make it clear that neither party intended for the FPA to be assumed and may be considered pursuant to O.C.G.A. § 13-2-2.

"A third party may [also] assume the [contractual] obligation… by implication where his conduct manifests an intent to become bound." *Sims,* 327 Ga. App. at 53, 755 S.E.2d at 525. There

[1] Though the communication gave 30 days' and not 180 days' notice, it expressed the clear intent to terminate the agreement.

is no genuine issue of fact as to whether NGMC Habersham conveyed an intent to be bound by the FPA. UHC's contends that NGMC Habersham implicitly assumed the contract or waived its ability to challenge rates by accepting payments in the contracted fee amounts. The parties have produced letters in discovery establishing that NGMC Habersham notified UHC that the FPA did not apply before the transaction was final. NGMC Habersham has a public website stating that it is not in network with UHC. NGMC Habersham filed this action less than a year after the dispute occurred. This is not a situation where UHC believed that Northeast Georgia Medical Center Habersham had agreed to accept the contracted rates of the FPA. There is no question that UHC was aware that NGMC Habersham believed that it was entitled to payment at out-of-network rates. UHC's own website reports that "NGHS has inaccurately communicated the Habersham Medical Center will be out of network." Under such circumstances, the Court declines to impose, and UHC provides no authority requiring, a business to dispute each transaction and refuse to accept even partial payment to avoid waiving its right to maintain an action establishing the application of a contract.

Finally, UHC argues that NGMC Habersham is a "mere continuation" of Habersham County Medical Center. "Common law continuation theory has been applied in Georgia where 'there is a substantial identity of ownership and a complete identity of the objects, assets, shareholders, and directors' as between the purchasing corporation and the selling company." *Perimeter Realty v. GAPI, Inc.*, 243 Ga. App. 584, 593, 533 S.E.2d 136, 145 (2000). Although called the "mere continuation of business" theory, a critical issue is whether there was a continuity of ownership. "[T]he key element of the mere continuation theory is a common identity of the officers, directors, and stockholders in the selling and purchasing corporations." *Datacom*

Warranty Corp. v. Phone Connection of Kan., 2006 U.S. Dist. LEXIS 76622, at *10 (N.D. Ga. Oct. 20, 2006) (citing *Bud Antle, Inc. v. Eastern Foods, Inc.*, 758 F.2d 1451, 1458-59 (11thCir. 1985)).

No issue of fact has been raised as to any identity of ownership, officers, shareholders or directors. Although NGHS assisted Habersham County Hospital Authority with the Hospital between January and July 2023, UHC recognizes in its Statement of Facts that the Habersham County Hospital Authority owned the Hospital until the transaction closing July 1, 2023, and NGHS reported to the Habersham County Hospital Authority. UHC's contention that the public owns or is effectively the shareholder for both Hospital Authorities is inconsistent with its admission that Habersham County Hospital Authority owned the hospital, and the assets were then purchased by the Hospital Authority of Hall County and the City of Gainesville. The Habersham County Hospital Authority and the Hospital Authority of Hall County and the City of Gainesville are not the same entity because they are Hospital Authorities. Hospital Authorities are individual, corporate governmental bodies with the power to enter and enforce contracts. O.C.G.A. § 31-7-72(a); O.C.G.A. § 31-7-75. HMC was owned and operated by one hospital authority, and its assets were purchased by a separate hospital authority. UHC has cited no authority enforcing the contracts of one Hospital Authority against another because both are entities of the State existing to serve the public.

Since July 1, 2023, the Hospital has been operated by NGMC Habersham. UHC has not named one director or officer of Habersham County Hospital Authority that is also an officer or director of NGMC Habersham, Northeast Georgia Health System, or the Hospital Authority of Hall County and the City of Gainesville. Petitioner's verified interrogatory responses establish that the leadership is different. Statements that the same care providers are available to provide treatment establishes only an identity of employees, which is not part of the inquiry. Nor is the fact

that the Hospital will continue to be operated as a hospital. *See Plaza Props.*, 240 Ga. App. at 642, 524 S.E.2d at 309.

The general rule of contracts that "a person who is not a party to a contract is not bound by its terms" controls the outcome of this case. *See Primary Investments, LLC v. Wee Tender Care III, Inc.*, 323 Ga. App. 196, 198-99, 746 S.E.2d 823, 827 (2013) (citation and internal quotations omitted). As no genuine issue of material fact remains as to this issue, Petitioner's Motion for Summary Judgment is hereby GRANTED. The FPA does not establish the fees applicable to services provided by NGMC Habersham after July 1, 2023.

IT IS SO ORDERED, this 1 day of Aug 2025.

JASON J. DEAL
Judge, Superior Court
Northeastern Judicial District

Order Prepared by:

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