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

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56 and Local Rules 7.1 and 56.1, Defendants Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. (collectively, "Georgia Medical Groups" or "GMGs") submit this Motion for Summary Judgment on all claims alleged in the Amended Complaint.

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

Respectfully submitted, this 27th day of February, 2026.

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CERTIFICATE OF COMPLIANCE

Pursuant to L.R. 7.1(D), I hereby certify that the foregoing document complies with the font and point selections approved by L.R. 5.1(C). The foregoing document was prepared using Times New Roman font in 14 point.

This 27th day of February, 2026.

/s/ James W. Cobb
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Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that I have 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.

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DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56(a), the Georgia Medical Groups,[1] by and through undersigned counsel, respectfully submit this Motion for Summary Judgment ("Motion") and state as follows:

PRELIMINARY STATEMENT

Discovery in this case has merely confirmed what was obvious from the start: United is not entitled to declaratory relief and the Court should enter judgment in favor of the GMGs. That is true for two primary reasons. First, this dispute is not amenable to declaratory relief because it is purely hypothetical. The GMGs do not intend to sue United for additional reimbursement on out-of-network claims under Georgia law, they have never threatened to sue United, and they have now expressly disclaimed their right to do so for any presently existing claim meeting the criteria United stated in its Amended Complaint.[2] Moreover, there are no medical facilities in the entire State of Georgia that are both out-of-network with United and staffed by the GMGs. As such, under present circumstances, it is impossible for a new disputed claim to arise. And while the Court found that it holds Article III jurisdiction based on the hypothetical possibility that a facility staffed by the GMGs

[1] The "Georgia Medical Groups" are Defendants Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C.

[2] Out-of-network claims for non-emergency services delivered at out-of-network facilities. (Dkt. 27, ¶ 47.)

may go out of network in the future and a disputed claim may thereafter arise, the relief United seeks is nonetheless untenable. That is because, given the speculative nature of this dispute, a declaratory judgment would require the Court to make multiple hypothetical assumptions about the nature of the at-issue claims, the contents of the governing plan documents, and the legal theories of relief the GMGs would assert (all of which differ from case to case, based on the factual circumstances and local law). It would thus be impossible for the Court to render a declaration of the parties' rights tailored to the established facts regarding their dispute, because there are no established facts and there is no dispute. (Part I.)

Second, even if the Court were willing to assume hypothetical facts and adjudicate the imagined dispute based on those assumptions (it should not), it still should enter summary judgment in favor of the GMGs because United's hypothetical claims would not be preempted. In *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020), the Supreme Court held unequivocally that ERISA does not preempt state regulation of medical reimbursement rates. *Id.* at 88. Thus, while ERISA does preempt state laws (and legal claims asserted thereunder) dictating which benefits ERISA plans must cover, it *does not* preempt state laws establishing the amounts ERISA plans must pay for benefits they independently choose to provide. The cases in other jurisdictions where TeamHealth-affiliated medical providers have challenged United's

reimbursement of out-of-network claims universally have involved claims that United adjudicated as payable and in fact paid. In those cases, the plaintiff medical groups challenged only the *amounts* paid on the covered claims, contending that state law compelled United to pay more. That is the sort of indirect cost regulation which post-*Rutledge* courts routinely have held is not preempted. Assuming the GMGs' hypothetical legal claims in this dispute would resemble the legal claims asserted in those prior cases, their claims also would not be preempted. (Part II.)

For these reasons, and as explained more fully below, the Court should enter summary judgment in favor of the GMGs.

STATEMENT OF FACTS & PROCEDURAL HISTORY

United and its affiliates are a health insurer and a third-party administrator ("TPA") for self-funded ERISA plans. (SUMF ¶¶ 1, 42.) In these roles, United reviews claims for medical services provided to its members and pays reimbursements to the medical providers. (SUMF ¶¶ 1, 40, 42.) The Georgia Medical Groups are medical practices that operate out of hospitals in Georgia. (SUMF ¶ 2.) They contract with those hospitals to provide emergency and non-emergency medical services to hospital patients. (*Id.*) The Georgia Medical Groups are affiliated with TeamHealth, a practice management entity with affiliated medical practices in forty-seven States. (SUMF ¶ 3.)

Since 2019, TeamHealth-affiliated practices in other jurisdictions have filed lawsuits against United asserting that the rates United paid on commercial, out-of-network emergency services and anesthesia claims were unlawfully low. (SUMF ¶¶ 4–5.) 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 health plans. (SUMF ¶ 6.)

In this action, United seeks a declaratory judgment that any state law legal claims that the GMGs may hypothetically assert in the future with respect to the reimbursement amounts paid for medical services delivered to United members in Georgia holding coverage under self-funded health plans are preempted. (SUMF ¶¶ 8–12, 25, 30–38.)

LEGAL STANDARD

Federal Rule of Civil Procedure 56(a) provides that "[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." The moving party bears the initial burden of establishing the absence of a genuine dispute of material fact. *Walker v. Darby*, 911 F.2d 1573, 1576 (11th Cir. 1990). Once the moving party has satisfied that burden by presenting evidence that, if uncontradicted, would entitle it to a directed verdict at trial, the burden shifts to the non-moving party

to present specific facts demonstrating a genuine dispute. *Id.* The non-moving party must present "enough of a showing that the jury could reasonably find for that party." *Id.* at 1577.

ARGUMENT

I. DECLARATORY RELIEF IS UNAVAILABLE BECAUSE THIS DISPUTE IS PURELY HYPOTHETICAL

The Court should grant summary judgment in favor of the GMGs because this dispute is not amenable to declaratory relief. United "seeks a declaration that the Non-Contractual State Law Claims that seek reimbursement in excess of the amounts determined in accordance with the rates and methodologies stated in the United Benefit Plans for out-of-network services are preempted by ERISA . . . ." (Dkt. 27, ¶ 83; SUMF ¶ 8, 10–11.) But the "Non-Contractual State Law Claims" do not actually exist. As the Court acknowledged in its January 12, 2026, Order denying the GMGs' Second Motion to Dismiss for Lack of Subject-Matter Jurisdiction, Mr. Bristow's Second Declaration[3] "protects United from an action based on any claim existing before April 18, 2025." (Dkt. 77, p. 9; SUMF ¶ 30.) Moreover, this action concerns only claims that are ineligible for arbitration under the federal No Surprises Act, meaning claims for out-of-network, non-emergency services that the GMGs delivered to United members at out-of-network facilities.

[3] (Dkt. 59–4.)

(Dkt. 77, p. 4; SUMF ¶ 38.) But those claims are purely hypothetical. As the Court further acknowledged, only one such claim arose in all of 2024, and there have been none in the nearly two years since. (Dkt. 77, p. 10; SUMF ¶¶ 36–37.) That is because since 2024, there have not been any facilities in the entire State of Georgia that are out-of-network with United and staffed by the GMGs. (*Id.*) As such, under present circumstances, it is impossible for a disputed reimbursement claim meeting United's parameters to arise. What United thus seeks is declaratory relief regarding the application of state law to imaginary future claims that may never materialize.

In its January 12, 2026, Order, the Court found that the hypothetical possibility a medical facility staffed by the GMGs may go out of network with United in the future, that the Georgia Medical Groups may provide covered, out-of-network, non-emergency care to a United member during this period, and that a disputed claim therefore may arise was sufficient to confer Article III jurisdiction over this declaratory judgment action.[4] (Dkt. 77, pp. 10–11.) Nonetheless, granting the relief United seeks is a separate question. It is well-established that "[f]or a declaratory judgment to issue, there must be a dispute which calls, not for an advisory opinion upon a hypothetical basis, but for an adjudication of present right ***upon established facts***." *Ashcroft v. Mattis*, 431 U.S. 171, 172 (1977) (emphasis

[4] The GMGs respectfully disagree with the Court's ruling and reserve their appellate rights on the jurisdictional issue.

added). Here, there are no "established facts" because the claims upon which United seeks declaratory relief do not exist. The Court would instead have to assume hypothetical facts. Thus, as a matter of law, a declaratory judgment cannot issue.

Further, this fundamental problem is more than a mere technicality. Because the disputed claims do not exist, it is unclear what types of medical services would be at issue in the hypothetical dispute (*i.e.*, hospitalist services vs. anesthesia services vs. obstetrical services etc.) That distinction is important, because the underlying ERISA health plans may have different reimbursement protocols for the different types of services. (SUMF ¶ 44.) Moreover, it is unclear which ERISA plans would give rise to the hypothesized disputed claims. That is significant because different plans have different reimbursement provisions for the same services. (SUMF ¶ 45.) It is also unclear what reimbursement amounts the GMGs hypothetically would demand under Georgia state law. While United alleges that TeamHealth-affiliated medical practices in other jurisdictions have brought suit contending they are entitled to reimbursement at amounts equaling their full billed charges (Dkt. 27, ¶ 9), the record shows that that has not universally been the case. In many of the disputes United identifies, the plaintiffs alleged entitlement to "reasonable" or "usual and customary" amounts, not necessarily their full billed charges.[5] (SUMF ¶¶ 6–7.)

[5] Notably, all of those cases dealt exclusively with out-of-network emergency medical claims or out-of-network claims for anesthesia services delivered at in-network facilities. (SUMF ¶ 5.) In other words, United has not identified a single

This compounding array of uncertainties and contingencies renders declaratory relief untenable. Even in the exceedingly unlikely scenario that a disputed claim were to materialize at some time in the future, there is no way to know how whatever measure of recovery the GMGs hypothetically would demand would correspond to the reimbursement provisions set forth in the hypothetical plan documents. Indeed, it is entirely possible that the recovery sought by the GMGs under state law would align with United's payment obligations under the plan terms. For instance, certain plans specifically delegate to United enormous flexibility to decide out-of-network reimbursement amounts, so state law requiring United to pay a certain amount would not conflict with any sort of fixed reimbursement provision in the plan terms. (SUMF ¶¶ 46–51.)

Finally, in additional to the uncertainty as to the critical facts regarding the hypothetical reimbursement claims, there is further uncertainty as to the legal theories of relief under which the GMGs would proceed in seeking additional reimbursement. As United concedes, the actions in which TeamHealth-affiliated medical providers in other jurisdictions have sued United under state law have involved claims for relief based on multiple different legal theories. (Dkt. 27, ¶ 10.)

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precedent example of a TeamHealth-affiliated provider bringing suit against United seeking additional reimbursement under state law for the types of claims at issue here: out-of-network, non-emergency claims delivered at out-of-network facilities. (SUMF ¶¶ 19–21, 30–31, 35–38.)

Of course, the plaintiffs in those other cases selected the various legal theories based on the facts presented in the specific disputes and local law in the given jurisdictions. For instance, the TeamHealth affiliates in Florida have sought additional reimbursement under Florida statutes regulating reimbursement amounts for out-of-network emergency claims. (SUMF ¶ 7.) Those claims are unique to Florida. The TeamHealth affiliates in Nevada sought compensation for United's alleged breaches of that State's Unfair Claims Practices Act. (*Id.*) The TeamHealth affiliates in New Jersey have sought compensation under a conversion theory. (*Id.*)

Here, because there are no actual disputed claims and the GMGs have expressly disclaimed any intention to sue United, there is no way to know what legal theories would be asserted in the hypothetical future action. (SUMF ¶¶ 30–31, 35–38.) That is significant, because even the authorities that have found ERISA preemption in payor/provider reimbursement disputes generally recognize that preemption is a claim-by-claim analysis based on the underlying facts and legal theories. *See, e.g., Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 242 (3d Cir. 2020) (in pre-*Rutledge* dispute over reimbursement amounts, finding that medical provider's unjust enrichment claim was preempted and claims for breach of oral contract and promissory estoppel were not preempted); *Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 387 (5th Cir. 2011) (finding medical provider's unjust enrichment and *quantum meruit* claims

preempted but claims for violations of the Texas Insurance Code, promissory estoppel, and negligent misrepresentation not preempted). Yet, here, the Court cannot know the relevant facts and legal theories, because the Georgia Medical Groups have never sought additional reimbursement on any underlying claims or asserted a legal basis to do so. Thus, to grant the relief United seeks, the Court would not only have to assume the existence of a hypothetical dispute, it would have to assume hypothetical facts and hypothetical legal theories. That is the antithesis of an "adjudication of present right upon established facts." *Ashcroft*, 431 U.S. at 172.

Accordingly, the Court should grant summary judgment for the GMGs because, on the record presented, declaratory relief is not an available remedy.[6]

II. ERISA DOES NOT PREEMPT STATE REGULATION OF MEDICAL REIMBURSEMENT RATES

[6] Notably, it is well-established that the Declaratory Judgment Act's permissive language "only gives the federal courts competence to make a declaration of rights; it does not impose a duty to do so." *Ameritas Variable Life Ins. Co. v. Roach*, 411 F.3d 1328, 1330 (11th Cir. 2005) (per curiam). As such, "district courts possess discretion in determining whether and when to entertain an action under the [DJA], even when the suit otherwise satisfied subject matter jurisdictional prerequisites." *Wilton v. Seven Falls Co.*, 515 U.S. 277, 282 (1995); *see also Cambridge Christian Sch., Inc. v. Fla. High Sch. Athletic Ass'n*, 942 F.3d 1215, 1251 (11th Cir. 2019) (noting that federal courts have "broad statutory discretion to decline declaratory relief," that the "remedy is nonobligatory," and that "in the declaratory judgment context, the normal principle that federal courts should adjudicate claims within their jurisdiction yields to considerations of practicality and wise judicial administration" (brackets and quotation marks omitted)).

To the extent the GMGs' imaginary state law claims can be discerned with sufficient precision for a hypothetical debate as to whether those claims would be preempted by ERISA, the court should hold that they would not be. In *Rutledge*, the Supreme Court made clear that ERISA does not preempt state laws which indirectly impose costs on ERISA plans without mandating a particular scheme of substantive coverage. That would be the case here. The GMGs' hypothetical claims would not be preempted because they merely would involve *United's* obligations under state law; they would not impose direct obligations on ERISA plans. The hypothetical claims tangentially would affect ERISA plans, if at all, only insofar as United would try to pass the added costs resulting from those claims on to the plans that it administers. Controlling Supreme Court precedent dictates that this is insufficient for preemption.

ERISA § 514(a)[7] directs that "this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Courts applying this provision are to avoid "uncritical

[7] ERISA is the rare federal statute giving rise to two varieties of preemption: complete preemption under § 502(a) and conflict preemption under § 514(a). These two doctrines are distinct, arise from separate sections of the ERISA statute, and employ different analyses. *See Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1343–44 (11th Cir. 2009) (explaining distinction between ERISA complete preemption and conflict preemption). This action addresses only conflict preemption under § 514(a).

literalism," recognizing that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655–56 (1995). Rather, courts must assume "that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress." *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016). Those categories are: (1) laws with "a 'reference to' ERISA plans," which include laws that "act[] immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation"; and (2) laws with "an impermissible 'connection with' ERISA plans, meaning a state law that 'governs a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Id.*

The GMGs' hypothetical future state law claims would not fall within either of the two categories. First, Supreme Court precedent makes clear that state laws which regulate ERISA plans and non-ERISA entities in an evenhanded manner and which "function[] irrespective of . . . the existence of an ERISA plan" do not "refer to" ERISA plans for purposes of conflict preemption. *See Ingersoll-Rand Co. v.*

McClendon, 498 U.S. 133, 139 (1990). In *Dillingham*, the Supreme Court held that a California state law was not preempted because the entities it regulated "need not necessarily be ERISA plans," although they could have been. 519 U.S. at 325. Similarly, the Supreme Court in *Travelers* upheld a New York state law that regulated the prices hospitals could charge to health insurers because the law applied regardless of whether the underlying health plans—whose costs were heavily affected by the law—were ERISA or non-ERISA plans. 514 U.S. at 656. These principles control here. The GMGs' legal claims would apply to underpaid claims for reimbursement regardless of whether the patients are insured under self-funded ERISA plans or non-ERISA governed health plans. (*See* SUMF ¶ 6.) As such, the GMGs' hypothetical state law claims would make no "reference" to ERISA plans.

The GMGs' hypothetical claims also would not have an "impermissible connection" with ERISA plans. In analyzing the "connection with" standard, the Supreme Court has "cautioned against an 'uncritical literalism' that would make pre-emption turn on 'infinite connections.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (citations omitted). Rather, courts must "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Id.* (citations and quotation marks omitted). ERISA's primary objective is "to make the benefits promised by an employer more secure by mandating certain oversight

systems and other standard procedures." *Gobeille*, 577 U.S. at 320–21. That goal is in no way obstructed by state law requiring health insurers to compensate medical providers at reasonable rates. *See Glastein v. Aetna, Inc.*, No. 18-9262, 2018 WL 4562467, at *3 (D.N.J. Sept. 24. 2018) (out-of-network provider's common law claims challenging insurer's reimbursement rates not preempted because "claims brought by a provider against an insurance company do not implicate ERISA's goals of protecting participants and beneficiaries. Such claims therefore do not have an 'impermissible connection with' an ERISA plan . . . .").

Rutledge is dispositive here. In that case, a unanimous Supreme Court, relying upon its prior decision in *Travelers*, held unequivocally that "ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." 592 U.S. at 88. *Rutledge* dealt with an Arkansas law regulating pharmacy benefit managers ("PBMs"). *Id.* at 83–84. PBMs are entities that manage prescription drug benefits for health plans, including ERISA plans. *Id.* This includes setting reimbursement rates and paying reimbursements to pharmacies for the plan members' prescription drugs. *Id.* at 84. After reimbursing the pharmacies, the PBMs are reimbursed by the health plans. *Id.* In this sense, PBMs are perfect

analogues for TPAs like United that manage health benefits for the plans.[8] Just as PBMs set reimbursement rates and pay reimbursements to pharmacies for pharmaceuticals dispensed to the plan members, United sets reimbursement rates and pays reimbursements to medical providers—such as the GMGs—who render medical care to the plan members. (SUMF ¶¶ 44–51.)

The state law at issue in *Rutledge* was a direct regulation of the reimbursement rates PBMs pay to pharmacies. Arkansas had sought to prevent the closure of rural pharmacies unable to turn a profit because PBMs set their reimbursement rates below the pharmacies' wholesale acquisition costs for the prescription drugs. *Id.* at 84. Arkansas law addressed this problem in part by setting a hard floor for the reimbursement rates PBMs could pay to pharmacies. *Id.* at 84–85. A PBM trade association challenged the law as preempted by ERISA § 514(a). The Supreme Court squarely rejected that position.

In reaching its decision, the Supreme Court made several crucial findings. One, the Court noted that "not every state law that affects an ERISA plan or causes

[8] Numerous courts have recognized that PBMs are third-party administrators of pharmacy benefits. *See, e.g.*, *Trone Health Servs., Inc. v. Express Scripts Holding Co.*, 974 F.3d 845, 848 (8th Cir. 2020) ("Pharmacy Benefit Managers (PBM) serve as third-party administrators of prescription drug programs sponsored by employers . . . ."); *Rx.com v. Medco Health Sols., Inc.*, 322 F. App'x 394, 396 (5th Cir. 2009) ("Defendants are pharmacy benefit managers ("PBMs"), which are third party administrators of prescription drug programs for health insurance plans, employers . . . .").

some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Id.* at 87. Two, the Court noted that "cost uniformity was almost certainly not an object of pre-emption."[9] *Id.* at 88. Accordingly, the Court held that the Arkansas PBM law did not have an "impermissible connection" with ERISA plans. *Id.* The Court further determined that the law did not "refer to" ERISA plans "because it applies to PBMs whether or not they manage an ERISA plan. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise. ***It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.***" *Id.* at 88–89 (emphasis added). The Court therefore concluded that the PBM law did not "require plan administrators to structure their benefit plans in any particular manner, nor did [it] lead to anything more than potential operational inefficiencies," and thus was not preempted. *Id.* at 89.

The potential Georgia state law doctrines at issue in this case—whatever they may be—would not be preempted for the same reasons set forth in *Rutledge*. As noted above, United's position as a TPA vis-à-vis the ERISA plans is perfectly analogous to that of the PBMs in *Rutledge*. Rather than manage the plans' prescription drug benefits and reimburse prescription drug claims, United manages the plans' health benefits and reimburses claims for medical services rendered.

[9] Indeed, the Supreme Court has long recognized "that ERISA was not meant to pre-empt basic rate regulation." *Travelers*, 514 U.S. at 667 n.6.

(SUMF ¶¶ 42–51.) And just like the law at issue in *Rutledge*, the doctrines that could underpin the GMGs' hypothetical claims would govern the reimbursement rates that United must pay for covered services rendered to plan members. As in *Rutledge*, the potential laws here would not impose obligations upon the ERISA plans themselves; they would impose obligations upon United, which is a service provider retained to administer the plans. (SUMF ¶¶ 39–40, 42.) In their disputes with United in other jurisdictions, TeamHealth-affiliated medical practices have not sued any plans because they have not sought recovery of benefits from the plans or otherwise alleged that the plans owe them anything. Those plaintiffs have alleged that *United* owed them additional payments based upon its breaches of independent state law duties requiring *United*—not the plans—to pay certain amounts. (SUMF ¶¶ 4–7.) And while judgments rendered against United conceivably have resulted in costs being shifted to the plans as United sought reimbursement from the plans, *Rutledge* makes clear that this sort of "indirect economic influence" is insufficient to trigger preemption. 592 U.S. at 87.

Notably, in the short time since *Rutledge*, numerous courts have relied upon that decision in concluding that claims asserted by medical providers against ERISA plan administrators challenging the reimbursement rates for out-of-network medical services under state law are not preempted by ERISA § 514(a). As the District of Connecticut observed several years ago, "***[e]very court confronted with this***

question has determined that ERISA does not preempt a law requiring insurers to reimburse emergency room physicians at a specific, possibly greater, rate." *NEMS PLLC v. Harvard Pilgrim Health Care of Conn. Inc.*, 615 F. Supp. 3d 125, 141–42 (D. Conn. 2022) (emphasis added).[10] And those prior courts' holdings are unassailably correct, because there is "no legally meaningful distinction, for

[10] *See also Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 658 F. Supp. 3d 1250, 1259 (S.D. Fla. 2023) (finding no preemption and explaining that the defendant-payer "misses the central holding of *Rutledge*, which is that a state law doesn't 'relate to' an ERISA plan if it merely 'establishes a floor for the cost of the benefits that plans choose to provide'"); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, at *8–9 (S.D.N.Y. Sep. 28, 2021) (no preemption where payer's "asserted liability does not derive from the particular rights and obligations established by any plan … [n]or do Plaintiffs allege a violation of any plan provision"); *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc.*, 2021 WL 4651504, at *3 (S.D. Fla. Sept. 21, 2021) (no preemption where "Plaintiff's claims are based on its interactions with Defendants independent of the Plan, and Plaintiff brings those claims in its own right and on its own behalf"); *Emergency Servs. of Okla., PC v. Aetna Health, Inc.*, 556 F. Supp. 3d 1259, 1263–65 (W.D. Okla. 2021) (no preemption because "the plans are not the factual basis for Plaintiffs' claims as Plaintiffs are not seeking payment under the plans and have not asserted their claims based upon any terms of any ERISA plan"); *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) (no preemption 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) (finding "emergency care statutes equate to cost regulation that does not bear an impermissible connection with or reference to ERISA, and are therefore not preempted"), *rev'd on other grounds*, 60 F.4th 899 (5th Cir. 2023); *United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in and for Cnty. of Clark*, 2021 WL 2769032, at *1 (Nev. July 1, 2021) (same).

purposes of express ERISA preemption, between an Arkansas law that regulates the rate at which PBMs reimburse pharmacies, and [state laws] which regulate the rate at which insurers and insurance plan administrators reimburse [medical providers]." *ACS*, 514 F. Supp. 3d at 941. There is no reason for the Court to depart from this clear judicial consensus.

CONCLUSION

For all the foregoing reasons, the Court should grant the Motion and enter summary judgment in favor of the Georgia Medical Groups and against United.

[signature on following page]

Respectfully submitted, this 27th day of February, 2026.

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I hereby certify that I have 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 27th day of February, 2026.

/s/ James W. Cobb
James W. Cobb
Georgia Bar No. 420133

Counsel for Defendants

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

STATEMENT OF UNDISPUTED FACTS IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule Civil Procedure 56 and Local Rule 56.1, Defendants, 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" or the "GMGs") submit this statement of undisputed material facts in support of Defendants' Motion for Summary Judgment.

The Parties and General Background

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.)

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.)

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.)

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

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.)

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 health 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).

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).

Procedural History

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.)

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.)

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

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.)

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.)

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.)

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.)

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.)

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.)

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 lawsuit. (Dkt. 31; Dkt. 31-1.)

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**.

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**.

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**.

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**.

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.

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.*

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.)

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.

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.)

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.)

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.)

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.

There are No Actual Disputed Reimbursement Claims

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.

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.

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.)

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

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.

Future, Hypothetical Claims

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**.

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.)

37. The Georgia hospitals where Defendants *do* provide services are all in-network with United. **Exhibit 10**, ¶ 5.

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*.).

Medical Claims Not At-Issue in this Litigation and the Plan Provisions

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

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.)

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

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.)

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

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.

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.

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").

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

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.").

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.

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.

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.").

Respectfully submitted, this 27th day of February, 2026.

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CERTIFICATE OF COMPLIANCE

Pursuant to L.R. 7.1(D), I hereby certify that the foregoing document complies with the font and point selections approved by L.R. 5.1(C). The foregoing document was prepared using Times New Roman font in 14 point.

This 27th day of February, 2026.

/s/ James W. Cobb
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Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that I have 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 notification of such filing to all counsel of record.

This 27th day of February, 2026.

/s/ James W. Cobb
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