## APPENDIX

A. *Memorandum Opinion* of the United States Court of Appeals for the Ninth Circuit, filed February 21, 2020.

B. *Minute Order Granting Summary Judgment* of the United States District Court for the Central District of California, filed October 6, 2017.

C. United States Supreme Court Order dated March 19, 2020, extending deadline to file petitions for writ of certiorari in light of the Covid-19 pandemic.

D. Pages 331 – 337 from the Excerpts of the Record filed in the Ninth Circuit on April 20, 2018.

App. 1

**APPENDIX – PART A**

804 Fed. Appx. 497, 2020 U.S. App. LEXIS 5543

Notice: Please refer to Federal Rules of Appellate Procedure 32.1 governing the citation to unpublished opinions.

United States Court of Appeals for the Ninth Circuit

IV SOLUTIONS, INC., a California corporation, Plaintiff-Appellant,

v.

PACIFICARE LIFE & HEALTH INSURANCE CO., an Indiana corporation; DOES, 1-30, inclusive,

No. 17-56609

Argued: January 8, 2020
Filed: February 21, 2020

Before: WATFORD and BENNETT, Circuit Judges, and SILVER**, District Judge.

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** The Honorable Jed S. Rakoff, United States District Judge for the Southern District of New York, sitting by designation.

App. 2

**[*498] MEMORANDUM***

IV Solutions, Inc. ("IVS") appeals the district court's grant of summary judgment on its breach of contract claim in favor of PacifiCare Life & Health Insurance Co. ("PacifiCare"). IVS also appeals the district court's denial of leave to amend its complaint. We have jurisdiction under 28 U.S.C. § 1291, and we affirm. As the [*499] parties are familiar with the facts, we do not recount them here.

We review de novo a district court's grant of summary judgment. *See Sonner v. Schwabe N. Am., Inc.*, 911 F.3d 989, 992 (9th Cir. 2018). Summary judgment is appropriate when, viewing the evidence in the light most favorable [**2] to the nonmoving party, "there is no genuine issue of material fact to be determined at trial." *Hernandez v. Spacelabs Med. Inc.*, 343 F.3d 1107, 1112 (9th Cir. 2003). We review a district court's denial of leave to amend for abuse of discretion. *See Bonin v. Calderon*, 59 F.3d 815, 845 (9th Cir. 1995).

IVS brought a breach of contract claim, alleging that, based on a third-party beneficiary theory, PacifiCare had a contractual duty to pay IVS for services that IVS provided to PacifiCare's insured. The district court determined that IVS's breach of contract claim for all but one of its claims for payment (i.e., Claims '215 and '245—'252) was barred by the four-year statute of limitations. *See* Cal. Civ. Proc. Code § 337(a). The parties agree that the four-year statute of limitations applies, but they disagree over when it started to run.

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* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

The limitations period started running when PacifiCare unequivocally denied IVS's claims for payment. *See Vishva Dev, M.D., Inc. v. Blue Shield of Cal. Life & Health Ins. Co.*, 2 Cal. App. 5th 1218, 207 Cal. Rptr. 3d 185, 189 (Ct. App. 2016). We agree with the district court that PacifiCare's Explanation of Benefits ("EOBs") for Claims '215 and '245-'252 were unequivocal denials. The EOBs contained clear language communicating that PacifiCare was denying the claims for payment, and nothing in the EOBs suggested that the denials were conditional or tentative. We therefore hold that IVS's breach of contract claim based on Claims '215 [**3] and '245-'252 is time-barred because the EOBs for those claims were unequivocal denials, and IVS filed suit more than four years after the date of the last EOB.

IVS's arguments to the contrary are unavailing. First, IVS argues that the EOBs were not unequivocal denials because they instructed IVS to "review the procedure codes" and "notify [PacifiCare] if any unusual treatments were performed or if there is additional information clarifying the services and/or charges." But as the district court correctly noted, PacifiCare did not condition its denial of IVS's claims on the receipt of new information, and its willingness to consider such information did not render its denial equivocal. *See Vishva Dev*, 207 Cal. Rptr. 3d at 190. Second, IVS argues that the district court failed to consider its equitable tolling argument based on PacifiCare's communications that it was reprocessing the claims. But the district court did consider this argument, and it determined that, even if the limitations period were equitably tolled for the five months during which PacifiCare was reprocessing the claims (from August 2012 to January 2013), the breach of

contract claim based on Claims '215 and '245-'252 would still be barred. IVS fails [**4] to show that this conclusion was erroneous. Third, IVS points out that in ruling on the motion to dismiss, the district court reached a contrary result – it determined that the EOBs were not unequivocal denials. But other than pointing out this fact, IVS does not present any legal authority or argument showing that the prior decision binds the district court or this court.

We also hold that the district court correctly determined that equitable estoppel does not apply to IVS's time-barred claims. Under California law, equitable estoppel does not apply when a plaintiff has ample time to sue after the conduct that has induced it to delay its suit ends. *See*, *e.g.*, *Mills v. Forestex Co.*, 108 Cal. App. 4th 625, 134 Cal. Rptr. 2d 273, 298 (Ct. App. 2003). [*500] PacifiCare's conduct that allegedly induced IVS to delay its suit ceased about three years before the limitations period lapsed. Three years was more than ample time for IVS to sue, and therefore equitable estoppel does not apply. *See Lobrovich v. Georgison*, 144 Cal. App. 2d 567, 301 P.2d 460, 464 (Cal. Ct. App. 1956).

As for IVS's breach of contract claim for its one remaining claim for payment (i.e., Claim '185), the district court determined that the claim failed because IVS was not a third-party beneficiary under the operative 2007 contract. A third party may enforce a contract if he is an intended beneficiary [**5] of the contract. *See* Cal. Civ. Code § 1559. "A third party may qualify as a beneficiary under a contract where the contracting parties must have intended to benefit that third party and such intent appears on the terms of the contract." *Jones v. Aetna Cas. &*

*Sur. Co.*, 26 Cal. App. 4th 1717, 33 Cal. Rptr. 2d 291, 295 (Ct. App. 1994).

We agree with the district court that, under the express terms of the 2007 contract, IVS was not an intended third-party beneficiary. IVS, however, argues that there is a material factual dispute over whether the operative agreement is the 2007 contract or a 2010 contract. In reviewing this argument, we are limited to the summary judgment record presented to the district court. *See Lippi v. City Bank*, 955 F.2d 599, 604 (9th Cir. 1992).

PacifiCare submitted evidence supporting that the operative agreement was the 2007 contract. In its opposition to summary judgment, IVS mentioned the existence of the 2010 contract and provided a heavily redacted copy of the 2010 contract, but it failed to explain why this was the operative agreement and how this agreement affected its claims. This was insufficient to create a genuine factual dispute.[1] *See Hernandez*, 343 F.3d at 1112 (stating that nonmoving party "cannot defeat summary judgment with allegations in the complaint, or with unsupported conjecture or conclusory statements"). Thus, the district court correctly [**6] determined that IVS's breach of contract claim as to Claim '185 fails because it was not an intended third-party beneficiary under the 2007 contract.

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[1] After oral argument, we ordered supplemental briefing on the applicability of the 2000 contract. The parties' supplemental briefs and supporting documents reveal that Pacificare had produced a largely unredacted copy of the 2010 contract days before it moved for summary judgment. IVS failed to review the document production before filing its opposition. But even after IVS realized that it had a copy of the largely unredacted 2010 contract, it did not seek any relief from the district court.

Finally, IVS argues that the district court abused its discretion by denying it leave to amend its complaint. But we agree with the district court that IVS's proposed amendments would not save its time-barred claims. The district court also found that IVS's proposed amendments would not save its breach of contract claim based on Claim '185, and IVS does not dispute that finding on appeal. Because IVS's proposed amendments would be futile, the district court did not abuse its discretion. *See Bonin*, 59 F.3d at 845.

AFFIRMED.[2]

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[2] We GRANT Pacificare's motion to seal Exhibits 1 and 3 attached to the Declaration of Rebecca Paradise. Dkt. No. 51. We also GRANT IVS's request to take judicial notice of Exhibits 1 and 3 attached to the Declaration of Eric Levinrad, Dkt. No. 56, which are the corporate Statements of Information for Viant, Inc. and Viant Payment Systems, Inc., filed with the California Secretary of State. *See* Fed. R. Evid. 201.

**APPENDIX – PART B**

Not Reported in Fed. Supp., 2017 WL 4541163

United States District Court for the Central District of California

IV SOLUTIONS, INC., Plaintiff,

v.

PACIFICARE LIFE AND HEALTH INSURANCE CO., Defendant.

Case No. CV 16-07153 SJO (MRWx)

Decided/Filed: October 6, 2017

Opinion by: S. JAMES OTERO, United States District Judge.

**[*1] ORDER (1) DENYING PLAINTIFF'S MOTION FOR LEAVE TO FILE SECOND AMENDED COMPLAINT** [Docket No. 34]**; (2) GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT** [Docket No. 36]

This matter is before the Court on (1) Plaintiff IV Solutions, Inc.'s ("IVS" or "Plaintiff") Motion for Leave to File Second Amended Complaint ("MFL"), filed August 21, 2017; and (2) Defendant PacifiCare Life and Health Insurance Company's ("PacifiCare" or "Defendant") Motion for Summary Judgment ("MSJ"), filed August 21, 2017. PacifiCare opposed the MFL ("MFL Opposition") on September 1, 2017, and IVS replied ("MFL Reply") on September 11,

2017. IVS opposed the MSJ ("MSJ Opposition") on September 1, 2017, and PacifiCare replied ("MSJ Reply") on September 11, 2017. The Court found this matter suitable for disposition without oral argument and vacated the hearing set for September 25, 2017. See Fed. R. Civ. P. 78(b). For the following reasons, the Court DENIES Plaintiff's MFL and GRANTS Defendant's MSJ.

## I. FACTUAL AND PROCEDURAL BACKGROUND

### A. Procedural Background

IVS initiated the instant insurance dispute in the Superior Court of the State of California for the County of Los Angeles on August 11, 2016. (*See* Notice of Removal, Ex. B ("Complaint"), ECF No. 1.) PacifiCare removed the action to this Court on September 22, 2016. (*See* Notice of Removal.) IVS asserted four causes of action against PacifiCare, including (1) fraud; (2) breach of contract; (3) breach of an implied-in-fact contract; and (4) quasi contract. (*See* Compl. ¶¶ 29–54.)

PacifiCare moved to dismiss the Complaint on October 28, 2016, and the Court, after considering the pleadings and moving papers, dismissed without leave to amend Plaintiff's third and fourth claims for breach of an implied-in-fact contract and quasi contract. (*See* Mot. to Dismiss, ECF No. 12; Order Granting in Part & Den. in Part Defendant's Mot. to Dismiss ("Dismissal Order"), ECF No. 20.) The Court also dismissed Plaintiff's first claim for fraud but granted leave to amend. (Dismissal Order 10.) Plaintiff responded by filing the First Amended Complaint ("FAC") on December 29, 2016, reasserting the claims for fraud and breach of contract. (*See*

generally FAC.) Plaintiff filed the MFL on August 21, 2017, seeking leave to amend its claim for breach of contract to newly assert the theory that MultiPlan acts as the agent for health insurers which are its clients. (MFL, ECF No. 34.) Defendant filed the MSJ on the same day, seeking to dismiss Plaintiff's remaining claims for fraud and breach of contract. (MSJ, ECF No. 35.) The parties subsequently filed a stipulation to withdraw the claim for fraud on September 12, 2017, which was granted by the Court on September 14, 2017. (Stipulation to Withdraw, ECF No. 47; Order Consenting to Withdrawal of Claim for Relief, ECF No. 49.) Only the claim for breach of contract remains.

B. Undisputed Facts

The following facts are either not in genuine dispute or are viewed in the light most favorable to IVS, the nonmovant.

[*2] PacifiCare is a health insurance company affiliated with United Healthcare Insurance Company ("United"). (Plaintiff's Statement of Genuine Disputes of Material Fact ("PSF") ¶ 1, ECF No. 44–17.) Prior to having its license revoked by the State of California, IVS was a California-based clinical home infusion pharmacy. (PSF ¶ 3.) IVS, an "out-of-network" provider not contracted in any way with PacifiCare, charged 50 times average wholesale price ("AWP") for the drugs and services it provided to patients. (PSF ¶¶ 4, 6.)

1. IVS Submits Claims to Pacificare

In June 2011, one of PacifiCare's members (hereinafter "CM") obtained a prescription from her oncologist for total parenteral nutrition ("TPN"), an intravenously administered nutritional formula composed

of proteins, electrolytes, fluid, sodium, potassium, and vitamins. (PSF ¶ 20.) CM's oncologist, unaware of IVS' inflated prices, referred the prescription to IVS. (PSF ¶¶ 21–23.) IVS sent a bill of charges to PacifiCare for services rendered to CM between June 4 and July 11 of 2011, which PacifiCare paid in full on September 14, 2011. (*See* Decl. Marlene Casillas in Opp'n to MSJ ("Casillas Decl."), Ex. 13 ("First EOB"), ECF No. 44–12.) The Explanation of Benefits ("EOB") sent along with the payment noted that "[t]he claim was processed according to the contracted rate with TRPN Three Rivers Provider Network." (First EOB 13.)

PacifiCare began to review the claims submitted by IVS with the assistance of ProPeer Resources, an independent review organization. (PSF ¶ 27.) At some point after September 2011, PacifiCare became aware that IVS' billed charges substantially exceeded PacifiCare's usual and customary out-of-network reimbursement rates. (PSF ¶ 28.)

On or around November 9, 2011, IVS billed PacifiCare approximately $922,000 for services rendered to CM between August 12 and October 4, 2011 (the " '245–'252 claims"). (PSF ¶¶ 26, 29.) Rather than pay the bill in full, PacifiCare used FAIR Health's Relative Value ("RV") Benchmark methodology to determine the usual and customary rate for the services provided by IVS. (PSF ¶ 32.) This total came out to $92,641.55, which PacifiCare paid to IVS on January 19, 2012. (PSF ¶ 33; Decl. Amy Gildernick in Supp. of MSJ ("Gildernick Decl."), Ex. B ("Second EOB"), ECF No. 37–1.) Accompanying the check was an EOB which set forth, on a claim-by-claim basis, what IVS charged, what PacifiCare paid, and an explanation for any discrepancy between the

charge and the payment. (PSF ¶ 34; Second EOB 4–29.) The explanations for the discrepancies included in relevant part that the "charge is more than the Maximum Allowable Charge or Usual and Customary amount payable by the plan. Please review the procedure codes and notify us if any unusual treatments were performed or if there is additional information clarifying the services and/or charges." (PSF ¶ 35; Second EOB 28.) The EOB also stated that "[i]f you believe the claim has been wrongly denied or rejected, you may have the matter reviewed by the California Department of Insurance" and that "you have the right to dispute" any denial of benefits "by submitting a written request" to PacifiCare. (PSF ¶¶ 36–38; Second EOB 29.)

PacifiCare also issued several other EOBs to IVS during this time period. One EOB, issued October 31, 2011, concerned two separate claims made by IVS to Pacificare: (1) a claim for services rendered to CM on July 11, 2011 (the " '185 claim") totaling $17,874.40; and (2) a claim for administration of a therapy drug to CM on July 2, 2011 (the " '215 claim") totaling $211,138.51. (Request for Judicial Notice ("RJN"), Ex. 8 ("Third EOB"), ECF No. 44–19.)[1] PacifiCare denied payment to IVS for the '185 claim on the basis that PacifiCare was "unable to determine benefits until we receive the medical rec-

[1] Plaintiff asks the Court to consider in ruling on the MSJ three exhibits attached to Plaintiff's RJN, which include two filings in other cases and an EOB submitted by PacifiCare to this action. (See RJN, ECF No. 44–18.) As the Court may take notice of proceedings and filings in this court or other courts, the Court finds consideration of these documents to be proper under Rule 201 of the Federal Rules of Evidence, and GRANTS Plaintiff's PRJN. *See U.S. ex rel. Robinson Rancheria Citizens Council v. Borneo, Inc.*, 971 F. 2d 244, 248 (9th Cir. 1992).

ords/billing information requested from the provider. When this information is received, we will reconsider the claim for benefits." (Third EOB 4.) In contrast, PacifiCare paid IVS $9,875.51 for the '215 claim, again noting that the $211,138.51 "charge is more than the Maximum Allowable Charge or Usual and Customary amount payable by the plan." (Third EOB 4.)

2. IVS' Efforts to Dispute the EOBs

[*3] On August 31, 2012, the Director of IVS called United in order to dispute the alleged non-payment or underpayment of its claims. (See Decl. Alex Vara in Opp'n to MSJ ("Vara Decl."), Ex. 1 ("8/31/2012 Tel. Tr."), ECF No. 44–2.)[2] Of the relevant claims, IVS first inquired about the '185 claim. (8/31/2012 Tel. Tr. 4–7.) When asked why the '185 claim was denied, the United representative stated, "They said they need medical records and it doesn't

[2] PacifiCare objects to the admission of the transcripts of telephone calls between IVS' Director and several United Employees, which are attached as Exhibits 1–5 of the Vara Declaration, on the following grounds: (1) these transcripts constitute inadmissible hearsay under Federal Rule of Evidence ("FRE") 801; and (2) these transcripts are irrelevant under FRE 402. The Court disagrees as to each of these objections. First, these messages constitute an opposing party's statement offered against that party and are therefore not hearsay, as these statements were made by United employees acting within the scope of their employment. *See* Fed. R. Evid. 801(d)(2)(A). Second, PacifiCare does not allege that these phone calls did not occur or that the transcripts are inaccurate, but merely that they are irrelevant to whether or not Plaintiff's claims were actually being reprocessed. However, evidence that United employees stated that the claims were being reprocessed is exactly relevant to whether or not they actually were being reprocessed, as well as to Defendant's belief or reliance on the belief that they were being reprocessed. Therefore, Defendant's objections to Exhibits 1–5 of the Vara Declaration are OVERRULED.

look like they got 'em for that date of service." (8/31/2012 Tel. Tr. 6.) After IVS insisted that every single claim it sent out had the same medical records, the United representative responded that "what I need to do is have a claims analyst give you a call." (8/31/2012 Tel. Tr. 6.) The United representative then asked IVS to list all of the disputed claims so that the claims analyst could locate them. (8/31/2012 Tel. Tr. 6.) IVS listed at least one of the '245–'252 claims. (8/31/2012 Tel. Tr. 8.)

IVS followed up with United on September 7, 2012. (Vara Decl., Ex. 2 ("9/7/2012 Tel. Tr."), ECF No. 44–3.) United again informed IVS that it did not process the '185 claim because they "were unable to determine benefits until we receive the medical records, billing information, requested from the provider." (9/7/2012 Tel. Tr. 2.) IVS insisted that "it's the same medical records, same diagnosis" as the other submitted claims, and the United representative agreed to "put that one back through." (9/7/2012 Tel. Tr. 2.) IVS also stated that "None of [the '245–'252 claims] were processed per our contract," and the United representative also agreed to "put those back through." (9/7/2012 Tel. Tr. 2–3.)

IVS again followed up with United on October 1, 2012. (Vara Decl., Ex. 3 ("10/1/2012 Tel. Tr."), ECF No. 44–4.) The United representative informed IVS that "[the '185 claim] I'm showing still pending, and [the '245–'252 claims], ah, let's see what's going on there. Okay. Those have been routed on 9/7 for an adjustment, it looks like they were not paid according to contract." (10/1/2012 Tel. Tr. 1.)

On October 12, 2012, the United representative informed IVS that $1,676.76 had been paid to IVS on

October 11, 2012 in satisfaction of the '185 claim. (Vara Decl., Ex. 4 ("10/12/2012 Tel. Tr."), ECF No. 44–5.) When IVS protested that this payment was too low, the United representative stated that IVS would need to "send in a letter of appeal." (10/12/2012 Tel. Tr. 2.) The United representative also told IVS that the '245–'252 claims "have not been reprocessed yet" because "I think they are waiting for the repricing from Multi–Plan." (10/12/2012 Tel. Tr. 1.)

IVS called United again on October 24, 2012. (Vara Decl., Ex. 5 ("10/24/2012 Tel. Tr."), ECF No. 44–6.) The United representative told IVS that she wasn't sure why the adjustment for the '245–'252 claims had not been completed, and asked IVS to hold while she checked on it. (10/24/2012 Tel. Tr. 2.) When she came back, the United representative informed IVS that she "finally found the information as to why these claims were priced the way they were," the reason being that "this was reviewed with our legal department and the documentation here by our claims director has indicated that per review with the legal department that they will be processing all those claims at the non–PPO pricing." (10/24/2012 Tel. Tr. 3.) When IVS informed the United representative that this was in violation of a contract, the United representative responded that "I routed an adjustment back in September, I don't know what happened to it." (10/24/2012 Tel. Tr. 3.) IVS then asked the representative what they could do "to get these claims paid properly," and the representative responded that she needed to "check with the supervisor who did this review." (10/24/2012 Tel. Tr. 4.)

[*4] On January 8, 2013, United sent a letter to IVS stating in relevant part:

> We received your correspondence dated November 1, 2012, requesting a review of the benefit determination for services rendered to [CM] on August 12, 2011, through October 4, 2011, by IV Solutions Home Infusion Pharmacy.
>
> PacifiCare Life and Health Insurance Company underwrites this fully-insured individual health insurance business.
>
> Your letter indicates that you believe the submitted claims are clean and there were no errors made. Your letter also indicates that having clarified your billing protocol; there should be no further delay in honoring your contract.
>
> Based on our review, we have determined that the claims were processed correctly according to [CM]'s insurance policy; therefore, no additional benefits are available.

(Vara Decl., Ex. 7 ("1/8/2013 Letter"), ECF No. 44–8.)

2. CM's Health Plan

At the time relevant to this action, CM was a member of PacifiCare's California Individual PPO plan. (PSF ¶ 2.) CM's health plan explicitly states that "Covered Expenses for Non–Participating Providers will not exceed the Usual and Customary Charges." (PSF ¶ 9; Decl. Kevin Cornish in Supp. of MSJ ("Cornish Decl."), Ex. D ("CM Health Plan"), ECF No. 38–2.) "Usual and customary charges" were defined as the lesser of (1) the provider's usual charge for its services; or (2) the charge PacifiCare determined to be the general rate charged by other providers for similar services in the same geographic area. (PSF ¶ 10; CM Health Plan.)

3. PacifiCare's Agreement with Concentra/MultiPlan

Effective February 1, 2007, United entered into a "Vendor Services Agreement" with Concentra Network Services, Inc. (PSF ¶ 12; Decl. Rebecca Paradise in Supp. of MSJ ("Paradise Decl."), Ex. A (the "Concentra Agreement"), ECF No. 36–1.) The Concentra Agreement governed the process by which PacifiCare would price claims for non-contracted, out-of-network providers. (PSF ¶ 13.) The Concentra Agreement was later assumed by Concentra's successor, MultiPlan, Inc. ("MultiPlan").[3] (PSF ¶ 13.)

PacifiCare would fax MultiPlan eligible claim forms submitted by out-of-network-providers. (PSF ¶ 13.) If the provider was part of MultiPlan's network, MultiPlan would fax PacifiCare pricing information for those claims pursuant to its arrangement with the provider. (PSF ¶ 14.) The Concentra Agreement states that "United shall make commercially reasonable efforts to request [MultiPlan] services on only those claims that have been determined to be payable and eligible for services. Despite these efforts, if United determines, at any time during the adjudica-

[3] IVS disputes whether or not the Concentra Agreement is the operative agreement governing the relationship between PacifiCare and MultiPlan, citing to a heavily redacted version of a 2010 agreement between United and MultiPlan that United filed in a different case. (MSJ Opp'n 15; RJN, Ex. 12, ECF No. 44–21.) IVS does not explain how or whether this new agreement affects the analysis of its claims, nor does IVS explain why the full text of this agreement could not have been produced before the close of discovery on July 24, 2017. Moreover, the agreement cited by IVS appears to contain many of the same or similar provisions as the Concentra Agreement described herein. The Court therefore finds that this is not a genuine dispute of material fact foreclosing summary judgment.

tion process, that the claim is NOT payable (in part or in full) or is not eligible for services, United reserves the right, at its sole discretion, to ... finalize the adjudication of such claim as it deems appropriate." (Concentra Agreement 16.) The Concentra Agreement also explicitly stated that "[t]he sole relationship of the parties is that of independent contractor and nothing in this Agreement or otherwise shall be deemed or construed to create any other relationship, including one of employment, joint venture or agency." (Concentra Agreement 9.) Finally, the Concentra Agreement stated that "[t]his Agreement shall not provide third parties with any remedy, cause, liability, reimbursement, claim of action or other right in law or in equity for any matter governed by or subject to the provisions of this Agreement." (Concentra Agreement 14.)

4. IVS' Agreement with Three Rivers Provider Network/Multiplan

[*5] Effective September 1, 2011, IVS entered into an agreement with MultiPlan. (Casillas Decl., Ex. 9 (the "MultiPlan Agreement"), ECF No. 44–10.) Under the MultiPlan Agreement, IVS agreed to accept 85–90% of its billed charges as payment for services provided to patients accessed through the MultiPlan Network. (MultiPlan Agreement 15–16.) The MultiPlan Agreement "requires Clients and/or Users, as appropriate, to compensate Network Providers for Covered Services rendered to Participants using only the Contract Rates, and Client/User shall not use any other savings or cost-containment arrangement that otherwise might be available to Client/User, including but not limited to, Client/User's own usual, and/or reasonable, and customary criteria." (MultiPlan Agreement 11.) Client is defined as "an insur-

ance company, employer health plan, Taft–Hartley Fund, or other organization that sponsors, or administers on behalf of a User, as applicable, one or more Programs for the provision of health care services to Participants accessing the Network." (MultiPlan Agreement 1.) Further, "MPI agrees that it has entered into agreements with Clients that specify that the right to access the Network, including access to the Contract rates, shall be subject to the terms of this Agreement." (MultiPlan Agreement 6.) However, "MPI does not determine benefits eligibility or availability for Participants and does not exercise any discretion or control as to Program assets, with respect to policy, payment, interpretation, practices, or procedures." (MultiPlan Agreement 6.)

IVS also maintained an agreement with Three Rivers Provider Network ("TRPN"), entered into on March 2, 2009. (PSF ¶ 72; Casillas Decl., Ex. 10 (the "TRPN Agreement"), ECF No. 44–11.) Under the TRPN Agreement, IVS agreed to accept 95% of its billed charges as payment for services provided to patients accessed through the TRPN Network. (PSF ¶ 73.) MultiPlan has a contract with TRPN allowing MultiPlan access to the TRPN Network. (Decl. Marc E. Rohatiner in Supp. MFL ("Rohatiner Decl.") ¶ 4, ECF No. 34.)

II. Defendant's Motion for Summary Judgment

Defendant makes three primary arguments in support of the MSJ: (1) Plaintiff's claims for breach of contract are barred by the statute of limitations; (2) Plaintiff has no standing to sue as a non-party to the Concentra Agreement; and (3) Defendant has not breached the Concentra Agreement as a matter of law. (*See generally* MSJ.) As the issue of summary

judgment is resolved on Defendant's first two arguments, the Court need not reach Defendant's third argument.

Rule 56(a) mandates that "the 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." Fed. R. Civ. P. 56(a). The moving party bears the initial burden of establishing the absence of a genuine issue of material fact. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). But if the nonmoving party bears the burden of proving the claim or defense, the moving party need not produce any evidence or prove the absence of a genuine issue of material fact. *See id.* at 325. Rather, the moving party's initial burden "may be discharged by showing–that is, point out to the district court–that there is an absence of evidence to support the nonmoving party's case." *Id.* (internal quotations omitted).

Once the moving party meets its initial burden, the "party asserting that a fact cannot be or is genuinely disputed must support the assertion." Fed. R. Civ. P. 56(c)(1). "The mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient; there must be evidence on which the jury could reasonably find for the plaintiff." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986); *accord Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986) ("[O]pponent must do more than simply show that there is some metaphysical doubt as to the material facts."). Further, "[o]nly disputes over facts that might affect the outcome of the suit ... will properly preclude the entry of summary judgment [and] [f]actual disputes that are irrelevant or unnecessary will not be counted." *Ander-*

*son*, 477 U.S. at 248; *see also Sanders v. Douglas*, 565 F. Supp. 78, 80 (C.D. Cal. 1983) (disregarding conclusory allegations of affidavit because "legal conclusions are totally ineffectual, and are not to be given consideration or weight whatsoever" on summary judgment). At the summary judgment stage, a court does not make credibility determinations or weigh conflicting evidence. *See Anderson*, 477 U.S. at 249. A court is required to draw all inferences in a light most favorable to the nonmoving party. *Matsushita*, 475 U.S. at 587.

A. The Statute of Limitations for Breach of Contract Claims

1. Legal Standard

a. Time of breach

[*6] Under California law, a claim for breach of written contract must be filed within four (4) years of the time of accrual. Cal. Civ. Proc. Code. § 337(1). "A cause of action for breach of contract accrues at the time of breach, when then starts the limitations period running." *Cochran v. Cochran*, 56 Cal. App. 4th 1115, 1120, 66 Cal. Rptr. 2d 337 (1997). "It is well-established that where a contract does not specify a time for performance, the party is obliged to perform within a reasonable time, and the statute of limitations begins to run when a 'reasonable time' has expired without performance." *IV Sols., Inc. v. United Healthcare*, No. CV 15–01418 DDP (SSx), 2015 WL 4127823, at *2 (C.D. Cal. July 7, 2015) (quoting Cal. Civ. Code § 1657; *Caner v. Owners' Realty Co.*, 33 Cal. App. 479, 481, 165 P. 727 (1917)). The statute of limitations generally commences when a party knows or should have known the facts essen-

tial to the claim. *See Gutierrez v. Mofid*, 39 Cal.3d 892, 896–897 (1985).

b. Equitable tolling/Equitable estoppel

"Equitable tolling is a judge-made doctrine which operates independently ... to suspend or extend a statute of limitations as necessary to ensure fundamental practicality and fairness." *Lantzy v. Centex Homes*, 31 Cal. 4th 363, 370 (2003). In the context of insurance, "equitable tolling runs after a timely claim for loss is tendered to the insurer while the insurer investigates the claim, until coverage is denied." *Flintkote Co. v. Gen. Acc. Assur. Co. of Canada*, 480 F. Supp. 2d 1167, 1178 (N.D. Cal. 2007) (citing *Prudential–LMI Commercial Ins. v.Super. Ct.*, 51 Cal.3d 674, 693 (1990)). "Once an unequivocal denial has been made, the insured's later requests for reconsideration do not serve the purposes of and do not extend the period of equitable tolling." *Singh v. Allstate Ins. Co.*, 63 Cal. App. 4th 135, 148. Further, "an insurer's willingness to consider additional evidence, or provide a voluntary appeal process, after it [has] given unequivocal notice that a claim was rejected [does] not toll the limitations period." *Vishva Dev, M.D., Inc. v. Blue Shield of California Life & Health Ins. Co.*, 2 Cal. App. 5th 1218, 1224 (Ct. App. 2016). However, because insurers are not obligated to reconsider a denied claim, equitable tolling may apply in the context of a previously denied claim "when the insurer has agreed to reopen and reinvestigate the claim." *Ashou v. Liberty Mut. Fire Ins. Co.*, 138 Cal. App. 4th 748, 762 (2006).

Application of the doctrine of equitable tolling must be "consistent with the policies underlying the

claim and limitation periods – e.g., the insurer is entitled to receive prompt notice of a claim and the insured is penalized for waiting too long after discovery to make a claim." *Id.* at 757 (citing *Prudential–LMI*, 51 Cal.3d at 692). "As with other general equitable principles, application of the equitable tolling doctrine requires a balancing of the injustice to the plaintiff occasioned by the bar of his claim against the effect upon the important public interest or policy expressed by the ... limitations statute." *Lantzy*, 31 Cal. 4th at 371.

An estoppel "arises as a result of some conduct by the defendant, relied on by the plaintiff, which induces the belated filing of the action." *Prudential–LMI*, 51 Cal.3d at 689–90. An "insurer that leads its insured to believe that an amicable adjustment of the claim will be made, thus delaying the insured's suit, will be estopped from asserting a limitation defense." *Id.* at 690 (citing *Benner v. Industrial Accident Comm'n.*, 26 Cal.2d 346, 350 (1945); *Lagomarsino v. San Jose Abstract & Title Insurance Co.*, 178 Cal.App.2d 455, 462 (1960)).

2. Discussion

[*7] Defendant argues that Plaintiff is barred by the four-year statute of limitations for breach of contract claims based on Defendant's unequivocal denial of all of Plaintiff's claims in EOBs dating on or before January 19, 2012. (MSJ 6–7.) Defendant relies on *Vishva Dev*, which held that a health insurance company's EOBs constituted an unequivocal denial of the plaintiff's claims despite language in the EOBs that stated that "[i[f you have questions about your claim or your claim has been denied and you believe that additional information will affect the processing of

your claim, you should contact [the] Customer Service Department." 2 Cal. App. 5th 1218, 1225 (Ct. App. 2016). Relying on *Singh*, the court concluded that "[t]he extension of a courtesy, to look at anything else that plaintiffs might have to offer, did not render the denial equivocal" as there was nothing "tentative or conditional" about the denials. *Id.* (citing *Singh*, 63 Cal.App.4th at 143.)

Plaintiff argues that Defendant's denials were not unequivocal, as the EOBs included language that asked claimants to "please review the procedure codes and notify us if any unusual treatments were performed or if there is additional information clarifying the services and/or charges." (MSJ Opp'n 9.) In addition, one of the EOB remark codes states that "[w]e are unable to determine benefits until we receive the medical records/billing information requested from the provider. When this information is received, we will reconsider the claim for benefits." (MSJ Opp'n 9.) Plaintiff also argues that even if the EOBs constitute an unequivocal denial, the doctrines of equitable tolling and equitable estoppel apply as Defendants agreed to reprocess Plaintiff's claims in September of 2012 and did not issue a final denial until January 8, 2013. (MSJ Opp'n 9–14.)

The Court agrees with Defendant that the majority of the EOBs constitute unequivocal denials. The language requesting that Plaintiff "review the procedure codes" and "notify if any unusual treatments were performed" were the exact kinds of "extension of courtesy" described in *Vishva Dev*. Defendant did not explicitly agree to reconsider the claims if new information were provided and was under no obligation to adjust the amount paid. The Court holds that the EOBs issued for the '215 claim and '245–'252

claims constitute an unequivocal denial of Plaintiff's claims.

The remark code for the '185 claim, however, includes an explicit promise to "reconsider the claim for benefits" once requested information was received from the provider. While presumably Defendant did not intend for Plaintiff to be allowed an indefinite period of time to submit this information, a time limit is not apparent on the face of the EOB or in any other evidence submitted by Defendant to this action. Full payment for the '185 claim was therefore not unequivocally denied until October 12, 2012, when the United representative informed IVS that $1,676.76 had been paid to IVS on October 11, 2012 in satisfaction of the '185 claim and that IVS would need to submit a letter of appeal for any further disputes.

Under California law, "separate, recurring invasions of the same right can each trigger their own statute of limitations." *Aryeh v. Canon Bus. Sols., Inc.*, 55 Cal. 4th 1185, 1198 (2013). Known as "continuous accrual," this doctrine applies "whenever there is a continuing or recurring obligation" and "each new breach of such an obligation provides all the elements of a claim–wrongdoing, harm, and causation." *Id.* However, "the theory of continuous accrual supports recovery only for damages arising from those breaches falling within the limitations period." *Id.* As Defendant's alleged breach is based on Defendant's ongoing obligation to pay the contract rate for submitted claims, and each of Defendant's denials could have constituted breach, denial of the '185 claim is an independently actionable wrong that triggers its own statute of limitations. As Plaintiff's filing date of August 11, 2016 is within the four-year

statute of limitations commenced on October 11, 2012, Plaintiff is not barred from bring an action based solely on the '185 claim.

[*8] As to Plaintiff's arguments for equitable estoppel and equitable tolling, the Court is skeptical that the same principles of equity apply where Plaintiff had over **three years** from the date of the alleged final denial to file suit as compared to the months for a one-year statute of limitations in Plaintiff's cited cases. *See IV Sols., Inc. v. United Healthcare*, No. CV 15–01418–DDP (SSx), 2015 WL 4127823, at *3 (C.D. Cal. July 7, 2015) ("the mere possibility of settlement, or ongoing efforts to settle, do not toll the statute of limitations – especially where the limitations period is lengthy enough to allow for attempts at settlement prior within the period"); *Transport Ins. Co. v. TIG Ins. Co.*, 202 Cal.App.4th 984 (2012) (expressing doubt that equitable tolling could apply to a contract claim, "in light of the lengthy statute of limitations involved"); Lantzy, 31 Cal.4th at 380 ("Because plaintiffs had three or four years after discovery, and up to ten years after the project's completion, to bring their suits for latent construction defects, many of the concerns that might warrant equitable tolling are ameliorated."). However, the Court need not reach this argument as Plaintiff's other claims are barred regardless of whether the Court does or does not apply the doctrine of equitable tolling.

"[T]he effect of equitable tolling is that the limitations period stops running during the tolling event, and begins to run again only when the tolling event has concluded. As a consequence, the tolled interval, no matter when it took place, is tacked onto the end of the limitations period, thus extending the deadline

for suit by the entire length of time during which the tolling event previously occurred." *Lantzy*, 31 Cal. 4th at 370–71. As held above, the '215 and '245–'252 claims were unequivocally denied as of January 12, 2012, the date the last EOB was issued for these claims. Absent any tolling period, the last date for Plaintiff to file suit would be January 12, 2016. Plaintiff alleges that Defendant was reprocessing Plaintiff's claims as early as August 11, 2012, and that final denial was not issued until January 8, 2013. (MSJ Opp'n 9–14.) At most, this represents a five month tolling period that would extend Plaintiff's deadline until June 15, 2016, two months shy of Plaintiff's August 11, 2016 filing date. Moreover, Plaintiff's claims of estoppel do not convince where Plaintiff was not diligent in pursuing its suit against Defendant for over three years following the ultimate denial of its claim.

The Court holds that IVS' claims for breach of contract are barred by the statute of limitations to the extent that they rely on the '215 claim or the '245–'252 claims, but that the statute of limitations does not bar a claim for breach of contract based on the '185 claim as a matter of law.

B. Plaintiff's Standing to Bring Suit as a Third-Party Beneficiary

1. Legal Standard

"A contract, made expressly for the benefit of a third person, may be enforced by him at any time before the parties thereto rescind it." Cal. Civ. Code § 1559. A third party "may qualify as a beneficiary under a contract where the contracting parties must have intended to benefit that third party and such intent appears on the terms of the contract." *Jones v.*

*Aetna Cas. & Sur. Co.*, 26 Cal. App. 4th 1717, 1724 (1994). If the terms of a contract "**necessarily** require the promisor to confer a benefit on a third person, the contract, and hence the parties thereto, contemplate a benefit to the third person. The parties are presumed to intend the consequences of a performance of the contract." *Johnson v. Holmes Tuttle Lincoln–Mercury, Inc.*, 160 Cal. App. 2d 290, 297 (1958). "Generally speaking, a health care service provider's agreement to pay for medical care is intended to benefit the enrollees, not treating physicians with whom there is no contractual relationship." *Ochs v. PacifiCare of California*, 115 Cal. App. 4th 782, 795 (2004). "Under ordinary circumstances, noncontracting health care providers ... would be only incidental beneficiaries of a contractual agreement to pay for an enrollee's medicare." *Id.*; *see also IV Solutions., Inc. V. United HealthCare Servs., Inc.*, No. CV 16–09598–MWF (AGRx), 2017 WL 3018079 (C.D. Cal. 2017).

2. Discussion

[*9] Defendant argues that Plaintiff does not have standing to bring suit for breach of the Concentra Agreement because Plaintiff is not a party to the agreement and is not a third-party beneficiary to the agreement. (MSJ 13–14.) Defendant points to the portion of the Concentra Agreement that prohibits third-party rights as evidence that the agreement was not intended to benefit third parties, and argues that any benefit to IVS under the agreement was only incidental. (MSJ 13–14.)

Plaintiff argues that inclusion of the third-party disclaimer is irrelevant as the contract as a whole clearly evidences the parties' intent to benefit medi-

cal providers. (MSJ Opp'n 16–17.) Plaintiff primarily relies on *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, which held that the question of a medical provider's third party beneficiary status under a similar agreement could not be resolved on a motion to dismiss, despite the inclusion of a third party disclaimer in the contract. No. CIV.A. 13–03101, 2015 WL 1954287, at *7 (E.D. Pa. Apr. 30, 2015). The *Aetna* court cited the portions of the agreement which obligated Aetna to "reprice the claims to reflect the Negotiated Rate" and "pay [the medical provider] at the Negotiated Rate for Covered Services rendered to Members." *Id.* at *8. The court noted that "[i]t would be difficult to imagine a beneficiary to be more intended than the third party a contracting party agrees to pay for services rendered" thus creating an ambiguity of whether or not the third-party disclaimer applied to medical providers. Id. at *8–*9 (citing *Temple Univ. Hosp., Inc. v. Grp. Health, Inc.*, 413 F.Supp.2d 420, 425 (E.D.Pa.2005)).

Plaintiff's argument fails. Under California law, the intended beneficiaries of agreements of this nature are generally the enrollees, not the providers. *Ochs*, 115 Cal. App. 4th at 795. Plaintiff does not cite any special circumstances which would evidence an intent to make the providers the beneficiaries; in fact, there is much evidence to the contrary. Unlike in *Aetna*, PacifiCare is not required to issue payments under the Concentra Agreement to providers as the agreement **expressly disclaims** any obligation to do so. The Concentra Agreement only requires that United "make commercially reasonable efforts to request [MultiPlan] services[.]" (Concentra Agreement 16.) It further states that "[d]espite these efforts, if United determines, at any time during the

adjudication process, that the claim is NOT payable (in part or in full) or is not eligible for services, United reserves the right, at its sole discretion, to ... finalize the adjudication of such claim as it deems appropriate." (Concentra Agreement 16.) As such, the contract does not **necessarily** require PacifiCare to confer a benefit on IVS, a fundamental aspect of obtaining third-party beneficiary status. *See Johnson*, 160 Cal. App. 2d at 297. Read in conjunction with the third-party disclaimer, IVS is foreclosed from claiming third-party beneficiary status under the Concentra Agreement as a matter of law.

III. Plaintiff's Motion for Leave to Amend the Complaint

Plaintiff also moves for leave to file a Second Amended Complaint ("SAC") in order to assert a theory of liability for breach of contract based on an agency relationship between MultiPlan and PacifiCare. (MFL 1.) Plaintiff seeks to assert this new theory based on (1) Plaintiff's discovery a few days prior to July 14, 2017, that PacifiCare did not have a contract with TRPN but instead had a contract with MultiPlan that gave it access to TRPN's network; and (2) Plaintiff's review of Plaintiff's own contract with MultiPlan in which MultiPlan acted as Defendant's agent and expressly agreed on behalf of Defendant that Defendant would be obligated to pay Plaintiff the MultiPlan contract rate. (Decl. of Marc E. Rohatiner in Supp. MFL ("Rohatiner MFL Decl.") ¶¶ 4–6, ECF No. 34.)

A. Legal Standard

[*10] Once 21 days after service of a pleading has passed, "a party may amend its pleading only with the opposing party's written consent or the court's

leave. The court should freely give leave when justice so requires." Fed. R. Civ. P. 15(a)(2). The Ninth Circuit considers five factors in determining whether leave to amend should be given: "(1) bad faith, (2) undue delay, (3) prejudice to the opposing party, (4) futility of amendment; and (5) whether plaintiff has previously amended his complaint." *Learjet, Inc. v. ONEOK, Inc.*, 715 F.3d 716, 738 (9th Cir. 2013) (citation omitted). Leave to amend lies "within the sound discretion of the trial court," and the court "must be guided by the underlying purpose of Rule 15–to facilitate decision on the merits rather than on the pleadings or technicalities." *DCD Programs, Ltd. v. Leighton*, 833 F.2d 183, 185–86 (9th Cir. 1987) (quoting *United States v. Webb*, 655 F.2d 977, 979 (9th Cir. 1981)).

B. Discussion

1. Bad Faith

There is no indication or evidence of bad faith by Plaintiff in filing the MFL. The Court finds that this factor weighs in favor of amendment.

2. Undue Delay

Plaintiff argues that there was no undue delay in filing the MFL because "[i]mmediately upon learning of the contractual relationship between PacifiCare and MultiPlan – and absence of a contractual relationship between PacifiCare and TRPN–IV Solutions sought to amend its complaint, first, by requesting PacifiCare's agreement to such a stipulation; and when such agreement was not forthcoming, by filing this motion for leave to amend." (MFL 3.) Plaintiff also notes that the parties had stipulated to a continuation of the October 24, 2017 trial date and associated deadlines in light of the new discovery on July

21, 2017, a little over one week after Plaintiff learned this information. (Stipulation to Continue Trial and Associated Deadlines, ECF No. 29.) The Court, however, denied the parties' stipulation on August 3, 2017. (Order Denied re Stipulation, ECF No. 31.) Despite this, and despite the looming trial deadline, Plaintiff submitted the MFL almost three weeks later on August 21, 2017. The Court finds that this factor does not weigh in favor of amendment.

3. Prejudice to the Opposing Party

Plaintiff concedes that the proximity of the trial and the cut-off of discovery will prejudice Defendant's ability to address the new theories asserted in the SAC. (MFL Reply 2.) Plaintiff argues, rather, that the proper course of action for the Court, given its purpose of facilitating decisions on the merits, is to continue the trial deadlines and give Defendant an adequate amount of time to respond. (MFL Reply 2–3.) As Plaintiff does not deny that granting the amendment as is will cause undue prejudice to Defendant, this factor weighs against amendment.

4. Futility of the Amendment

Although plaintiffs are usually afforded the opportunity to test their claims on the merits, "futile amendments should not be permitted." *Klamath–Lake Pharm. Ass'n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1293 (9th Cir. 1983). It is not an abuse of discretion to refuse a request to amend when the proffered amendment is merely a "restatement of the same facts in different language or the reassertion of a claim previously determined." *Kasey v. Molybdenum Corp. of Am.*, 467 F.2d 1284, 1285 (9th Cir. 1972).

As described above, all of Plaintiff's claims save the '185 claim are barred from recovery by the statute of limitations. The '185 claim concerns services rendered to CM on July 11, 2011. Plaintiff's contract with MultiPlan and its corresponding benefits did not go into effect until September 1, 2011. The '185 claim would therefore not have been processed under Plaintiff's contract with MultiPlan, but under Plaintiff's contract with TRPN. Indeed, all of the claims IVS cites to that PacifiCare processed prior to September 1, 2011 include the statement that "[t]he claim was processed according to the contracted rate with TRPN Three Rivers Provider Network." (First EOB 13.) Plaintiff's claim that MultiPlan represented itself as an agent of PacifiCare in the terms of its agreement with IVS is therefore irrelevant, and leave to amend would be futile.

5. Previous Amendments

[*11] While Plaintiff has previously amended the Complaint, the facts necessary to assert Plaintiff's new theory were not available at the time of previous amendment. *See Jackson*, 902 F.2d at 1388; *United States v. Pend Oreille Pub. Util. Dist. No. 1*, 926 F.2d 1502, 1511 (9th Cir. 1991). This factor is neutral.

The Court finds, however, that Defendants would be undeniably prejudiced by this amendment and leave to amend would be futile. The factors in total weigh strongly against amendment.

IV. CONCLUSION

For the foregoing reasons, the Court GRANTS Defendant Pacificare Life and Health Insurance Company's Motion for Summary Judgment as to Plaintiff's remaining causes of action and DENIES Plaintiff IV Solutions, Inc.'s Motion for Leave to File

Second Amended Complaint. Defendant shall lodge a proposed judgment within seven (7) days of the issuance of this Order. The parties' pending Motions in Limine will be DENIED as moot.

IT IS SO ORDERED.

Dated: October 6, 2017.

/s/ S. James Otero

S. JAMES OTERO

UNITED STATES DISTRICT JUDGE

## APPENDIX – PART C

United States Supreme Court

(Order List: 589 U.S.)

**THURSDAY, MARCH 19, 2020**

**ORDER**

In light of the ongoing public health concerns relating to COVID-19, the following shall apply to cases prior to a ruling on a petition for a writ of certiorari:

IT IS ORDERED that the deadline to file any petition for a writ of certiorari due on or after the date of this order is extended to 150 days from the date of the lower court judgment, order denying discretionary review, or order denying a timely petition for rehearing. See Rules 13.1 and 13.3.

IT IS FURTHER ORDERED that motions for extensions of time pursuant to Rule 30.4 will ordinarily be granted by the Clerk as a matter of course if the grounds for the application are difficulties relating to COVID-19 and if the length of the extension requested is reasonable under the circumstances. Such motions should indicate whether the opposing party has an objection.

IT IS FURTHER ORDERED that, notwithstanding Rules 15.5 and 15.6, the Clerk will entertain motions to delay distribution of a petition for writ of certiorari where the grounds for the motion are that the petitioner needs additional time to file a reply due to difficulties relating to COVID-19. Such motions will

ordinarily be granted by the Clerk as a matter of course if the length of the extension requested is reasonable under the circumstances and if the motion is actually received by the Clerk at least two days prior to the relevant distribution date. Such motions should indicate whether the opposing party has an objection.

IT IS FURTHER ORDERED that these modifications to the Court's Rules and practices do not apply to cases in which certiorari has been granted or a direct appeal or original action has been set for argument.

These modifications will remain in effect until further order of the Court.

**APPENDIX – PART D**

Pages 331 – 337 from the Excerpts of the Record filed in the Ninth Circuit on April 20, 2018.

United States Bankruptcy Court
Central District of California
Western Division

IV SOLUTIONS, INC., a California corporation,
Plaintiff

v.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, an Indiana corporation; and DOES 1 through 30, inclusive, Defendants.

Case No. 2:16-cv-07153-SJO-MRW

Before: OTERO, United States District Court Judge.

**PLAINTIFF IV SOLUTIONS, INC.'S NOTICE OF REQUEST AND REQUEST FOR JUDICIAL NOTICE IN OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT OR IN THE ALTERNATIVE PARTIAL SUMMARY JUDGMENT**

Pursuant to Federal Rules of Evidence, Rule 201, Plaintiff IV Solutions, Inc. ("Plaintiff") hereby respectfully requests that this Court take judicial notice of the following documents, all of which have been filed in connection with this and other actions:

1. The opposition of Plaintiff IV Solutions, Inc. to a summary judgment motion in the case *IV Solutions, Inc. v. TakeCare Insurance Company, Inc.*, United States Central District of California Case No. 2:13-cv-4592-JFW, a true and correct copy of which is attached as Exhibit 11.

2. Excerpts of the Network Access Agreement between United HealthCare Insurance Company and Multiplan, Inc. and TRPN filed in the case *IV Solutions, Inc. v. United HealthCare Services, Inc.*, United States Central District of California Case No. 2:16-cv-09598-MWF, a true and correct copy of which is attached as Exhibit 12.

3. An Explanation of Benefits authored by PacifiCare, filed as an exhibit by PacifiCare in the case *IV Solutions, Inc. v. Pacificare Life and Health Insurance Co.*, United States Central District of California Case No. 2:16-cv-07153-SJOMRWx, a true and correct copy of which is attached as Exhibit 8.

The Court may take notice of proceedings and filings in this court or other courts. *U.S. ex rel. Robinson Rancheria Citizens Council v. Borneo, Inc.*, 971 F. 2d 244, 248 (9th Cir. 1992).

Dated: September 1, 2017

/s/ Eric Levinrad

ERIC LEVINRAD

Attorney for Plaintiff IV SOLUTIONS, INC.

**EXHIBIT 8**

**EXHIBIT A**

PACIFICARE
C/O PO BOX 19032
GREEN BAY, WI 54307-9032
**ADDRESS SERVICE REQUESTED**

UnitedHealthcare
PacifiCare®

EXPLANATION OF BENEFITS
(This is not a bill)

Page 1 of 3

If you have any questions, please call us at 800-232-5432

To report fraud, contact (866) 283-7354

#BWNCHDS
#P296215579600013#
IV SOLUTIONS HOME INFUSION PHARMACY
3384 NOTER AVE
LOS ANGELES CA 90034

| SERVICE DATES | AMOUNT CHARGED | PROVIDER DISCOUNT | NOT COVERED | COVERED AMOUNT | DEDUCTIBLE | COPAY | COINSURANCE | REMARK CODE | TOTAL AMT PAID |
|---|---|---|---|---|---|---|---|---|---|
| **CLAIM #:** 005018110-00-0185 | | | **CUSTOMER:** MOORE, CARROLL C | | | **PROVIDER:** IV SOLUTIONS HOME INFUSION PHA | | | |
| **ID #:** 7600-036005 | | | **PATIENT:** MOORE, CARROLL C | | | **ACCOUNT #:** 202356 | | | |
| 07/11/2011-07/11/2011 | 7800.00 | | 7800.00 | | | | | 649 | |
| B4193-JW-MEDICAL SERVICES | | | | | | | | | |
| 07/11/2011-07/11/2011 | 8221.20 | | 8221.20 | | | | | 649 | |
| B4185-JW-MEDICAL SERVICES | | | | | | | | | |
| 07/11/2011-07/11/2011 | 1058.00 | | 1058.00 | | | | | 649 | |
| B4216-JW-MEDICAL SERVICES | | | | | | | | | |
| 07/11/2011-07/11/2011 | 794.90 | | 794.90 | | | | | 649 | |
| J1815-JW-MEDICAL SERVICES | | | | | | | | | |
| CLAIM SUMMARY: | 17874.10 | | 17874.10 | | | | | | |

| DATE | PAYMENT NUMBER | PAYMENT AMOUNT | PAYMENT ISSUED TO: | YTD DEDUCTIBLE REMAINING NETWORK | YTD DEDUCTIBLE REMAINING NON-NETWORK | YTD COINSURANCE REMAINING |
|---|---|---|---|---|---|---|
| 10/31/2011 | 029446770 | 9875.51 | IV SOLUTIONS HOME INFUSION PHARMACY | | | |

FM-07011-02

SAVE THIS COPY FOR YOUR RECORDS

UnitedHealthcare
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C/O PO BOX 19032
GREEN BAY, WI 54307-9032

Claims Paying Account
KEYBANK NATIONAL ASSOCIATION
58-704/412

029446770 10/31/2011 9875.51

NINE THOUSAND EIGHT HUNDRED SEVENTY FIVE DOLLARS 51/100**********

IV SOLUTIONS HOME INFUSION
PHARMACY
3384 NOTER AVE
LOS ANGELES CA 90034



⑈029446770⑈ ⑆041207040⑆ 3509935168621⑈

| SERVICE DATES | AMOUNT CHARGED | PROVIDER DISCOUNT | NOT COVERED | COVERED AMOUNT | DEDUCTIBLE | COPAY | COINSURANCE | REMARK CODE | TOTAL AMT PAID |
|---|---|---|---|---|---|---|---|---|---|
| **CLAIM #:** 005018110-00-0215 | | | **CUSTOMER:** MOORE, CARROLL C | | | | **PROVIDER:** IV SOLUTIONS HOME INFUSION PHA | | |
| **ID #:** 7600-036005 | | | **PATIENT:** MOORE, CARROLL C | | | | **ACCOUNT #:** 202356 | | |
| 07/02/2011-07/02/2011 J2505-Injectable Drug | 70300.00 | | 60550.00 | 9750.00 | | | | 010 | 9750.00 |
| 07/02/2011-07/02/2011 S9537-IV Therapy OP Pro Fee | 158.00 | | 113.00 | 45.00 | | | | 010 | 45.00 |
| 07/02/2011-07/02/2011 J2505-Injectable Drug | 70300.00 | | 70300.00 | | | | | 010 | |
| 07/02/2011-07/02/2011 J2505-Injectable Drug | 70300.00 | | 70300.00 | | | | | 010 | |
| 07/02/2011-07/02/2011 00019-Interest | 80.51 | | | 80.51 | | | | 370 | 80.51 |
| CLAIM SUMMARY: | 211138.51 | | 201263.00 | 9875.51 | | | | | 9875.51 |

**Remarks :**

010 This charge is more than the Maximum Allowable Charge or Usual and Customary amount payable by the plan. Please review the procedure codes and notify us if any unusual treatments were performed or if there is additional information clarifying the services and/or charges.

370 This payment is for accumulated interest earned on the claim as required by the state.

649 We are unable to determine benefits until we receive the medical records/billing information requested from the provider. When this information is received, we will reconsider the claim for benefits. Please refer to the Right to Collect Necessary Information provision in the plan description for additional information.

PACIFICARE
C/O PO BOX 19032
GREEN BAY, WI 54307-9032
**ADDRESS SERVICE REQUESTED**

UnitedHealthcare
PacifiCare



**California Providers:** If you believe the claim has been wrongfully denied or rejected, you may have the matter reviewed by the California Department of Insurance at: California Department of Insurance, [Appeal_Address]Division, 300 S. Spring Street, South Tower, Los Angeles, California 90013. The website is: www.insurance.ca.gov. Inquiries may also be made to (213) 897-8921 (for Los Angeles residents), (800) 927-4357 (for all other CA residents), or (800) 482-4833 for Telephone Device for the Deaf (TDD).

Per California law, PACIFICARE LIFE AND HEALTH INSURANCE COMPANY is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit a request to: PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, PO Box 13597 Green Bay, WI 54307-3597.

Please note if you disagree with this benefit denial, you have the right to dispute it. You may do so by submitting a written request to PACIFICARE LIFE AND HEALTH INSURANCE COMPANY at the aforementioned address. We urge you to call or write us first before contacting the California Department of Insurance so that we may try to resolve any concerns.