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Comprehensive Spine Care, P.A., Plaintiff, v. Horizon Blue Cross Blue Shield of New Jersey, Inc., Defendants,	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY DOCKET NO. BER-L-203-03 CIVIL ACTION OPINION

Argued: June 6, 2003

Maxine H. Neuhauser, Esq., appearing on behalf of defendant, Horizon Blue Cross Blue Shield of New Jersey, Inc. (Epstein Becker & Green P.C.)

Eric D. Katz, Esq. appearing on behalf of plaintiff, Comprehensive Spine Care, P.A. (Nagel Rice Dreifuss & Mazie, LLP).

Decided: June 6, 2003

Peter E. Doyne, P.J.S.C.

Introduction

Before the court is an application by defendant, Horizon Blue Cross Blue Shield of New Jersey, Inc. ("Horizon") for an order pursuant to R. 4:6-2(e), dismissing plaintiff's, Comprehensive Spine Care, P.A. ("CSC"), complaint in the instant matter. The application is opposed and oral argument was requested and conducted.

Relevant Procedural History and Statement of Facts

Plaintiff in the instant matter seeks payments and damages for medical services provided to patients covered by contracts with Horizon under the theories of promissory estoppel (first count), negligent misrepresentation (second count), common law fraud (third count), statutory violations of the New Jersey Consumer Fraud Act, N.J.S.A. 56:8-1 et. seq. ("CFA") (fourth count), and unjust enrichment (fifth count).

Horizon is a non-profit health service corporation authorized and established under the Health Service Corporations Act, N.J.S.A. 17:48E-1 to –48 ("HSC Act"). Horizon members, known as subscribers, can be covered under a variety of benefit plans that provide payment for health care services received by its subscribers.

The HSC Act empowers Horizon to pay benefits for the health care services provided by physicians participating in a Horizon network, i.e., physicians who have a contractual agreement with Horizon. See N.J.S.A. 17:48E-10(b); see also Somerset Ortho. v. Horizon Blue Cross & Blue Shield, 345 N.J.Super. 413, 419 (App.Div. 2001). HSC does permit Horizon to pay claims for health care services provided by non-participating physicians. See N.J.S.A. 17:48E-1 et seq.; see also Somerset, supra, 345 N.J.Super. at 421. Participating or network providers have a contractual right to receive payment directly from Horizon while non-participating providers do not. See Id. at 414.

Horizon subscriber insurance contracts contain an anti-assignment provision, which Horizon asserts, requires or permits it not to accept or honor assignments of benefits made to non-participating providers. As to each plan, statutory and contractual provisions entitle Horizon to refuse to pay non-participating physicians directly. See Somerset, supra, 345 N.J.Super. at 414. Horizon may choose to make direct payments to

a non-participating provider, without such payment constituting an assignment of benefits:

> A typical standard form anti-assignment clause in such contracts provides: "No assignment or transfer by you of any of your interest under this policy is valid unless we consent thereto. However, we may, in our discretion, pay a provider directly for services rendered to you.

Somerset, supra, 345 N.J.Super. at 414 n.3 (quoting N.J.A.C. 11:20-App. A, B, C, D, E, U).

CSC specializes in orthopedic surgery and treatment of the spinal cord and is a non-participating provider of the Horizon network. Plaintiff asserts that it has not filed this suit nor is it claiming injury, based upon assignments of benefits from the defendant's subscribers. Rather, the plaintiff seeks damages based upon Horizon's purported intentional and negligent misrepresentations of coverage and its breach of payment promises made directly to the provider prior to the plaintiff's rendering of medical services to more than twenty five Horizon subscribers.

Barbara Ben-Yishay ("Ben-Yishay"), practice administrator for the plaintiff, certifies that CSC confirms payment and coverage terms with Horizon before rendering services to Horizon's subscribers. Ben-Yishay asserts that plaintiff relies completely on the insurer's representations in performing medical services and expects payment based on those representations. Ben-Yishay certifies that for each of the subscribers and services at issue, Horizon promised plaintiff that they would be paid the "usual and customary" fee ("U & C fee"). In addition, Ben-Yishay certifies that before CSC rendered services to the Horizon subscribers each patient executed an agreement with

CSC promising to immediately forward to the practice any payments made by Horizon directly to that patient for services rendered.

Ben- Yishay certifies that the medical / managed care industry has long recognized that the U & C fee is the amount normally charged by non-participating providers, like CSC, to their patients in the free market without a written provider agreement with an insurance company in exchange for obtaining access to the insurance company's subscribers. Moreover, Ben- Yishay posits that it is universally understood in the industry that the U & C fee means the usual charge for a particular service by providers in the same geographic area with similar training and experience.

Specifically, before rendering any non-emergency services, plaintiff allegedly first contacted Horizon and obtained directly from the defendant a pre-authorization to treat the patient and, in each instance, a pre-certification of coverage at which time Horizon purportedly represented to the plaintiff that it would pay the U & C fee. Pre-authorization and pre-certification according to Ben-Yishay are universally accepted procedures that is required by managed care insurers, including Horizon, and is utilized by providers including CSC.

The purpose of obtaining pre-authorization and pre-certification according to Ben-Yishay is to confirm that the managed care insurer is authorizing the treatment to be rendered and that the insurer is agreeing to pay for that treatment. Thus, Ben-Yishay asserts that CSC must rely completely on Horizon's coverage and payment representations before agreeing to render medical services to the defendant's subscribers if CSC is to conduct a profitable business. Ben-Yishay certifies that if Horizon had advised plaintiff at the beginning that it would not pay the U & C fee, CSC would have

declined to render treatment unless they were able to independently determine that the subscribers had the personal financial resources to meet the payment obligations.

Ben-Yishay certifies that at no time did Horizon retract its purported pre-authorization for treatment, its pre-certification coverage or its agreement that it would allegedly pay plaintiff the U & C fee for the subscribers and services at issue. However, it is asserted by plaintiff that they have not been appropriately compensated in accordance with Horizon's coverage and payment representations as CSC has only been paid a fraction of the amount promised to them by Horizon and is consequently owed several hundred thousand dollars.

Horizon asserts that a feature of nearly all managed care systems is the utilization control procedures of pre-authorization and pre-certification. According to Horizon, pre-certification of coverage acknowledges the medical necessity for the treatment and level of care being proposed in advance of it being rendered. Further, pre-authorization refers to the procedure used to review and assess the medical necessity for the treatment and level of care being proposed, in advance of it being rendered and pre-authorization refers to the procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency out-patient services before the services are provided. Horizon urges that neither of these utilization control procedures guarantees any particular level of benefit and is performed for the benefit of the patient, not the provider.

Horizon asserts that pre-authorization and pre-certification do not create an independent basis for payment and plaintiff's attempt to convert the utilization control mechanisms of pre-authorization and pre-certification to a promise to pay a certain

amount corrupts the system. Horizon's position is that to permit CSC to receive all the benefits of in-network status while avoiding entering into a service provider agreement would be wholly unfair and would debase the whole statutory system. Horizon further asserts that plaintiff should collect the purported outstanding fees it is owed from its patients and that it has refrained from doing so which should not serve to create any liability on the part of Horizon.

Analysis

The standard governing analysis of a motion to dismiss for failure to state a claim pursuant to R. 4:6-2(e) is that the complaint must be examined "in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned even from an obscure statement of claim, opportunity being given to amend if necessary." Printing Mart-Morristown v. Sharp Elecs. Corp., 116 N.J. 739, 746 (1989). At this preliminary stage of the litigation the court should not be concerned with the ability of plaintiff to prove the allegation contained in the complaint. See Id. at 746. The plaintiff is entitled to every reasonable inference of fact and the examination of a complaint's allegation of fact required by the aforestated principles should be one that is at once painstaking and undertaken with a generous and hospitable approach. See Id. "Courts should grant these motions with caution and in 'the rarest instances.' " Ballinger v. Delaware River Port Auth., 311 N.J.Super. 317, 322 (App.Div.1998), quoting Printing Mart, supra, 116 N.J. at 772.

A motion for dismissal for failure to state a cognizable claim pursuant to R. 4:6-2(e) should be based on the pleadings, with the court accepting as true the facts alleged in the complaint. See Rieder v. State Dept. of Transportation, 221 N.J.Super. 547, 552,

(App.Div.1987). Nevertheless, the motion should be granted if even a generous reading of the allegations does not reveal a legal basis for recovery. See Edwards v. Prudential Property and Casualty Company, 357 N.J.Super. 196, 202 (App.Div. 2003). "The motion may not be denied based on the possibility that discovery may establish the requisite claim; rather, the legal requisites for plaintiff's claim must be apparent from the complaint itself." Edwards, supra, 357 N.J.Super. at 202.

However, where "matters outside the pleadings are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided by R. 4:46" after reasonable opportunity is provided to present all material pertinent to such a motion. R. 4:6-2.

In the instant matter, the defendants are presenting materials outside of the pleadings in making their motion to dismiss. However, pursuant to R. 4:6-2, the court at this early stage of the proceedings, will not engage in a review of documents outside of the pleadings so as to covert the matter to a summary judgment determination pursuant to R. 4:46.

In the Somerset matter, the Appellate Division held that the assignment of benefits were not enforceable against Horizon as:

(1) the assignment of benefits violated public policy; and,
(2) Horizon has a valid, enforceable anti- assignment clause in its contract with its subscribers.

Somerset, supra, 345 N.J.Super. 413 (The anti-assignment clause that invalidated the assignment of health insurance benefits without the consent of the non-profit health service corporation is valid. Encouraging broad participation in a network of plan medical providers is inherent in the statutory mandate requiring the non-profit health

insurance corporation to control costs and the clause is an important inducement to medical providers to join the corporation's insurance networks.) The Somerset court recognized that "Horizon is wholly a creature of the Legislature who imbued this health service corporation with a unique public interest role and empowered it with the means generally recognized as vital to that role." Id. at 422. The Somerset court further noted that "the Legislature expressly contemplated an in-network of participating medical providers who agree to negotiate pre-arranged costs in exchange for direct payment." Id. at 420.

Accordingly, given the strong public interest role Horizon plays, the Somerset court upheld the anti-assignment clauses contained in Horizon's subscriber insurance contracts as enforceable and rejected a non-participating service provider's attempt to evade the statute by having horizon subscribers assign their benefits to the non-participating service providers. Id. at 422-423. In a case cited by Horizon in its brief, Spine Sports Medicine of New Jersey v. Horizon Blue Cross / Blue Shield of New Jersey, Ber L 863-00 (Law Div. December 6, 2002), this court in an oral opinion dismissed the complaint of an out-of-network provider seeking direct payment from Horizon for medical services rendered to Horizon subscribers on the basis that Somerset was controlling. The court notes that the Spine Sports decision was by way of a summary judgment application and not a R. 4:6-2(e) application as is the instant application.

It is the position of Horizon that plaintiff is essentially attempting to make an end-run around the HSC Act and the subscribers' coverage contracts by couching its lawsuit as a promissory estoppel, fraud and negligent misrepresentation action based upon the mere fact that Horizon provided pre-certification of coverage and / or pre-authorization of

treatment. Horizon asserts that if the court permits plaintiff to assert such a position it would defeat the whole purpose of the HSC Act and would create a new cause of action the was expressly rejected by the Appellate Division in the Somerset ruling.

However, the dispute in Somerset did not involve purported misrepresentations of coverage or alleged false promises of payment. The issue presented by the plaintiff in the instant matter is substantially different as it is whether a non-participating provider has a legal recourse against an HMO that purportedly misrepresented payment and coverage to the provider who then renders services in reliance on the alleged promises. Somerset does not address that particular issue. Accordingly, the causes of action brought by the plaintiff in the instant matter are not solely based on an assignment of rights or benefits from Horizon's subscribers but rather arise out of alleged direct dealings between Horizon and CSC.

Promissory Estoppel Claim

The first count of plaintiff's complaint seeks relief under a promissory estoppel theory. Plaintiff bases this promissory estoppel claim on the fact that CSC "obtained approval from Horizon by way of pre-authorization for treatment and pre-certification of coverage... prior to performing 'medically necessary' surgical procedures and prior to providing 'medically necessary' treatment on said patients." To establish promissory estoppel a plaintiff must prove four separate elements:

1) a clear and definite promise by the promisor;
2) the promise must be made with the expectation that the promisee will rely thereon;
3) the promisee must in fact reasonably rely on the promise; and
4) detriment of a definite and substantial nature must be incurred in reliance on the promise.

Pop's Cones, Inc. v. Resorts Int'l Hotel, Inc., 307 N.J.Super. 461, 469 (App.Div. 1998) (citing Malaker Corp. Stockholders Protective Comm. v. First Jersey Nat'l Bank, 163 N.J.Super. 463, 479 (App.Div. 1978), cert. denied 79 N.J. 488 (1979)).

In the instant matter, plaintiff alleges that prior to rendering medical services to the subscribers CSC obtained from Horizon pre-certifications of coverage and promises of payment at the practice's U & C fees. Plaintiff asserts that each pre-certification of coverage constituted a definite promise by the promisor, Horizon. Moreover, CSC alleges that that they reasonably relied on the promise of payment and consequently provided the medical services to Horizon's subscribers. In addition, plaintiff alleges monetary damages based on its reliance upon Horizon's pre-certifications.

The court is satisfied that by giving plaintiff every reasonable inference, plaintiff has alleged the requisite elements of promissory estoppel and defendant's application to dismiss count one of the plaintiff's complaint is denied.

Negligent Misrepresentation Claim

In the second count of the complaint, plaintiff seeks relief for negligent misrepresentation alleging that Horizon "negligently refused to pay certain claims and, in addition negligently used and / or manipulated data that understated the U & C fees for medical services provided by" CSC. Plaintiff further contends that it "reasonably expected and relied upon what it believed to be Horizon's honest representations that the plaintiff would be properly compensated in accordance with the pre-certification of coverage." In addition, CSC asserts that based on its reliance it suffered "significant money damages."

To recover damages for economic loss or injury sustained based on negligent misrepresentation, plaintiff must prove that incorrect statement was negligently made and justifiably relied upon, and that injury was sustained as consequence of that reliance. See Kaufman v. I-Stat Corp., 165 N.J. 94 (2000).

In the instant matter, plaintiff alleges that prior to rendering medical services to the subscribers CSC obtained from Horizon pre-certifications of coverage and promises of payment at the practice's U & C fees. Plaintiff asserts that each pre-certification of coverage constituted a definite promise by Horizon which they reasonably relied on and consequently provided the medical services to Horizon's subscribers. As a result, plaintiff alleges monetary damages based on its reliance upon Horizon's pre-certifications.

The court is satisfied that by giving plaintiff every reasonable inference, plaintiff has alleged the requisite elements of negligent misrepresentation and defendant's application to dismiss count two of the plaintiff's complaint is denied.

Common Law Fraud Claim

In the third count of the complaint, CSC seeks relief under common law fraud. Plaintiff alleges that Horizon made false promises to pay claims and that when CSC agreed to perform health care services for Horizon members, it "reasonably expected and relied upon what it perceived to be Horizon's honest representations that it would be properly compensated." Plaintiff further alleges that it was damaged by this alleged reliance, stating that it suffered "significant money damages" as CSC was not fully compensated by Horizon in accordance with Horizon's coverage and payment representations.

The essential elements of a claim for fraud are: "1) a material misrepresentation of a presently existing or past fact; (2) knowledge or belief by the defendant of its falsity; (3) an intention that the other person rely on it; (4) reasonable reliance thereon by the other person; and (5) resulting damages." Gennari v. Weichert Co. Realtors, 148 N.J. 582, 610 (1997); See also McConkey v. AON Corp., 354 N.J.Super. 25, 45 (App.Div. 2002).

R. 4:5-2 requires that "a pleading which sets forth a claim for relief... shall contain a statement of the facts on which the claim is based, showing that the pleader is entitled to relief." Under this rule, conclusory statements without supporting facts are insufficient to state a claim. See Delbridge v. Office of the Public Defender, 238 N.J.Super. 288, 313 (Law Div. 1989). Where, as here, allegations of fraud are involved, the pleading requirements are even stricter, for R. 4:5-8 dictates that " in all allegations of misrepresentation [or] fraud,... particulars of the wrong, with dates and items if necessary, shall be stated insofar as practicable."

In the instant matter, plaintiff's allegations regarding Horizon's purported misrepresentations are lacking in the necessary specific details and therefore they must be dismissed for lack of specificity under R. 4:5-8(a). Count three of the plaintiff's complaint is therefore dismissed without prejudice. CSC has failed to allege how many claims were submitted, who the patient subscribers were, which Horizon plan each patient subscriber belonged to, when and to whom the claims were submitted, how much reimbursement was promised by whom and when, how much was actually reimbursed by Horizon and how much CSC reasonably expected.

Where the fraud pleading does not include the required specificity, the pleader should ordinarily be afforded the opportunity of amending the pleading. See Rebish v. Great Gorge, 224 N.J.Super. 619 (App.Div. 1988). Therefore, plaintiff will be permitted twenty days to re-file an amended complaint in which count three of the complaint meets the strict pleading requirements of R. 4:5-8(a).

Plaintiff is obligated to state, to the extent known, which representative or representatives from Horizon made the purported representations in question to Ben-Yishay. In addition, plaintiff is to state what the Horizon representative(s) said to Ben-Yishay concerning the payment of claims up to the U & C fee during the pre-certification and pre-authorization process, how and when this alleged representation was conveyed to Ben-Yishay, the form and amount the purported payment was to take if so specified and how much was actually reimbursed by Horizon to CSC. Furthermore, plaintiff is to set forth how many claims were submitted and the identity of subscribers in question.

Consumer Fraud Act Claim

The fourth count of plaintiff's complaint alleges a violation of the CFA. The plaintiff asserts that as a "direct commercial competitor" of Horizon's network providers, it was induced into rendering medically necessary care to the defendant's subscribers by the promise of payment in accordance with the pre-certification of coverage.

Contrary to that purported promise, it is alleged that Horizon failed to pay CSC by the use of deceptive and unconscionable commercial practices including Horizon's blatant misrepresentation of its payment promise, its manipulation and skewing of data used to calculate the reimbursement due to the plaintiff and its providing of incomplete or evasive explanations concerning the manner in which Horizon calculated its

reimbursement rates. In summary, plaintiff alleges that Horizon has denied CSC the opportunity to fairly compete with Horizon's network providers through unlawful means and has compromised the plaintiff's ability to provide continuity of care and the requisite level of care to its patients.

The CFA is intended to protect consumers who purchase "goods or services generally sold to the public at large". Marascio v. Campanella, 298 N.J.Super. 491, 499 (App.Div.1997). While the term "consumer" has historically connoted an individual purchaser, the CFA has been interpreted to afford protection to corporate and commercial entities who purchase goods and services for use in their business operations. See Hundred East Credit Corp. v. Eric Schuster, 212 N.J.Super. 350 (App.Div.), certif. denied, 107 N.J. 60 (1986); Coastal Group, Inc. v. Dryvit Systems, Inc., 274 N.J.Super. 171 (App.Div.1994).

As remedial legislation, the provisions of the CFA are to be "construed liberally in favor of the consumer to accomplish its deterrent and protective purposes." Lettenmaier v. Lube Connection, Inc., 162 N.J. 134, 139 (1999). "The language of the CFA evinces a clear legislative intent that its provisions be applied broadly in order to accomplish its remedial purpose, namely to root out consumer fraud." Lemelledo v. Beneficial Mgmt. Corp., 150 N.J. 255, 264 (1997) (The CFA "encompasses the sale of insurance policies as goods and services that are marketed to consumers.") The Lemelledo court explained:

> The CFA explicitly states that the rights, remedies and prohibitions that it creates are cumulative to those created by other sources of law. Furthermore, the CFA, in allowing for private suits in addition to actions instituted by the Attorney General, contemplates that consumers will act as "private attorneys general." Eliminating CFA remedies for otherwise-covered practices may undermine that important and calculated legislative objective.

Id. at 268.

Thus, "a court must look to whether a real possibility of conflict would exist if the CFA were to apply to a particular practice, regardless of the number of agencies with regulatory jurisdiction over that practice." Id.

At the same time, the CFA is not intended to cover every transaction that occurs in the marketplace. Its applicability is limited to consumer transactions which are defined both by the status of the parties and the nature of the transaction itself. See City Check Cashing, Inc. v. National State Bank, 244 N.J.Super. 304 (App.Div.1990) (The court held that a check cashing service was not a "consumer" of bank services within the meaning of the CFA.) Also see BOC Group v. Lummus Crest, Inc., 251 N.J.Super. 271 (Law Div.1990) (The court held that the purchaser of an experimental petroleum refining concept and services incidental thereto was not a "consumer" of "merchandise" under the CFA.)

In Feiler v. New Jersey Dental Ass'n, 191 N.J.Super. 426 (Ch.Div. 1983), a non-profit dental association had standing under the CFA to complain that a dentist gained an unfair competitive advantage over its individual members by fraudulent billing practices, in that the dental association's individual members had standing to assert such cause of action.

Pursuant to N.J.S.A. 56:8-4, the Attorney General is empowered to promulgate rules and regulations necessary to accomplish the objective of the CFA. Pursuant to this authority, the Division of Consumer Affairs has identified various types of consumer transactions for goods and/or services to which the CFA applies. The list provides insight into the types of transactions envisioned to be within the scope of the CFA. These include

automotive repairs and advertising, delivery of household furniture and furnishings, disclosure of refund policies in retail establishments, home improvement practices, merchandise advertising, the servicing and repair of home appliances and the sale of animals and meat. See N.J.A.C. 13:45A-1.1 et seq.

While the CFA applies to protect the consumers from sharp practices in marketing of both goods and services, hospital services which are regulated by Department of Health do not fall within purview of CFA. See Hampton Hosp. v. Bresan, 288 N.J.Super. 372, 381-382 (App.Div. 1996).

In General Dev. Corp. v. Binstein, 743 F.Supp. 1115 (D.N.J. 1990), a real estate development company, which was neither a consumer nor a competitor in the commercial sense with the property owners' association, had induced its customers to join in a class RICO action against it. The court determined it did not have standing to bring a cause of action under the CFA. See Id. In Conte Bros. Automotive, Inc. v. Quaker State-Slick 50, Inc., 992 F.Supp. 709 (D.N.J. 1998), a retailer of engine additive products was ruled to lack standing to sue under the CFA based on a claim of false advertising by defendant manufacturers and marketers of competing products as the retailer did not qualify as "consumers" and also were not direct competitors of the defendants.

Plaintiff is not a purchaser or a consumer of any goods or services from Horizon. To the contrary, plaintiff is a provider of services to patients who happen to be Horizon members. Plaintiff's medical services are not consumables under the CFA and the value of its health care services can neither be diminished nor affected by any act of Horizon.

The court does not accept the assertion that plaintiff is a direct commercial competitor of Horizon. While it is true that plaintiff might be a commercial competitor of

Horizon's network providers, that fact standing alone cannot lead the court to find that plaintiff is a direct commercial competitor of a non-profit health service corporation established by the Legislature.

Lastly, plaintiff does not fall into the exception of a non-profit organization suing to protect the interests of its members. See Feiler, supra, 191 N.J.Super. 426. Therefore, plaintiff cannot act as a representative of its subscriber patients in a CFA action. This is particularly so in light of the anti-assignment provision.

As a result, because plaintiff is not a "consumer" nor a "commercial competitor" within the meaning of the CFA, and as the services at issue are not "consumer transactions" regulated by the CFA, the transactions at issue are not subject to the CFA and plaintiff lacks standing to sue.

The transactions in the instant matter do not constitute common commercial activity designed to attract the patronage of the public. Horizon does not market or advertise its services to non-participating providers. Moreover, Horizon does not solicit its members to use non-participating providers by offering them incentives or by assuring its members that the out-of-network provider will receive above-market compensation or extra-fast payment.

The court makes no ruling as to whether applying the CFA to the instant matter would conflict in any way with the regulatory scheme embodied in New Jersey insurance statutes and regulations.

For the forgoing reasons, plaintiff's fourth count of the complaint alleging a violation of the consumer fraud act is dismissed with prejudice.

Unjust Enrichment Claim

In the fifth count of the complaint, plaintiff alleges that by keeping money that purportedly should have been paid to plaintiff Horizon was unjustly enriched.

The doctrine of unjust enrichment rests on the equitable principle that a person shall not be allowed to enrich himself unjustly at the expense of another. See Callano v. Oakwood Park Homes Corp., 91 N.J.Super. 105, 108 (App.Div.1966). "The key words are enrich and unjustly" Id. at 109. To recover under the unjust enrichment doctrine the plaintiff must prove "that the defendant received a benefit and that retention of the benefit without payment therefore would be unjust." VRG Corp. v. GKN Realty Corp., 135 N.J. 539, 554 (1994).

In the instant matter, plaintiff argues that Horizon received a benefit when health care services were provided to Horizon subscribers. Therefore, plaintiff asserts that if Horizon did not pay plaintiff for the services rendered it would be unjust because Horizon collects fees from its subscribers and / or their employers for health insurance and the subscribers did in fact receive medical care from CSC. In addition, plaintiff alleges that it expected remuneration from Horizon through its reliance on Horizon's purported promise concerning the payment of claims up to the U & C fee during the pre-certification and pre-authorization process.

The court is satisfied that by giving plaintiff every reasonable inference, plaintiff has alleged the requisite elements of unjust enrichment and defendant's application to dismiss count five of the plaintiff's complaint is denied.

Conclusion

For the foregoing reasons, Horizon's application to dismiss counts one, two and five of the complaint is denied. Count three of the complaint is dismissed

without prejudice and the plaintiff is permitted twenty days to re-file an amended complaint in which count three of the complaint meets the strict pleading requirements of R. 4:5-8(a). Finally, count four of the complaint is dismissed with prejudice. Plaintiff's counsel is to prepare the appropriate order pursuant to the five-day rule and to disseminate this letter opinion to all counsel of record.