UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

THE AMERICAN PSYCHIATRIC ASSOCIATION, THE NEW YORK STATE PSYCHIATRIC ASSOCIATION, on their behalf and in an associational capacity on behalf of their members, and MILEN BEYENE, VALERIA CALDERON, ELIZABETH CANTY, BONNIE DORIS ELLIOTT, DANIEL RICCOBONO, and NIMROD SHIMRONY, on behalf of themselves and all others similarly situated, Plaintiffs, v. EMBLEMHEALTH, INC. and EMBLEMHEALTH PLAN, INC., Defendants.	Case No. 1:25-cv-10783-JGK Hon. John G. Koeltl

DEFENDANTS EMBLEMHEALTH, INC. AND EMBLEMHEALTH PLAN, INC.'S NOTICE OF MOTION TO DISMISS

PLEASE TAKE NOTICE that Defendants EmblemHealth, Inc. and EmblemHealth Plan, Inc. shall move this Court before the Honorable John G. Koeltl of the United States District Court for the Southern District of New York, located at 40 Foley Square, New York, NY 10007, on such date and time as the Court may direct, for an Order pursuant to Rules 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure to dismiss the Plaintiffs' Complaint. Defendants request the Court hear oral argument on the Motion to Dismiss.

PLEASE TAKE FURTHER NOTICE that in support of their Motion to Dismiss, Defendants will rely upon the accompanying Memorandum of Law, the Declaration of Amanda H. Freyre and Exhibits A and B attached thereto, the pleadings, papers, and other documents on file, and such further evidence or argument as the Court may consider.

Dated: April 3, 2026
New York, New York

Respectfully Submitted,

PILLSBURY WINTHROP SHAW PITTMAN LLP

By: _/s/ Amanda H. Freyre_____

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this 3rd day of April 2026.

/s/ Amanda H. Freyre
Amanda H. Freyre

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MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' COMPLAINT

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Defendants EmblemHealth, Inc. and EmblemHealth Plan, Inc. (collectively, "EmblemHealth" or "Defendants") respectfully submit this Memorandum of Law in Support of their Motion to Dismiss the Complaint (the "Compl." or "Complaint") filed by the American Psychiatric Association ("APA"), the New York State Psychiatric Association ("NYSPA," and together with the APA, the "Association Plaintiffs"), and six individual Emblem plan member plaintiffs (the "Plan Member Plaintiffs" and, collectively with the Association Plaintiffs, "Plaintiffs") pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6).

I. PRELIMINARY STATEMENT

Plaintiffs' 259-paragraph Complaint is an exercise in futility. On February 19, 2026, the New York Attorney General and EmblemHealth entered into an Assurance of Discontinuance (the "AOD")[1] that addresses every category of harm alleged and provides every form of relief now sought—except for penalties sought but precluded by New York law. The AOD requires Defendants to undertake a comprehensive, years-long remediation effort to correct the very provider directory issues at the heart of the Complaint. Despite being given the opportunity to amend their pleading at a recent pre-motion conference, Plaintiffs chose to ignore this dispositive development. The Complaint fails as a matter of law for multiple, independent reasons.

First, the Association Plaintiffs lack Article III and statutory standing under the Lanham Act—the sole basis for federal subject matter jurisdiction. They are not commercial enterprises

[1] The AOD is attached as Exhibit B to the Declaration of Amanda H. Freyre (the "Freyre Declaration") in Support of Defendants' Motion to Dismiss ("Ex. B"). In consideration of the Freyre Declaration, including its attached Exhibits A and B, Defendants respectfully request that the Court take judicial notice of Ex. B. *See Simeone v. T. Marzetti Co.*, No. 21-CV-9111 (KMK), 2023 WL 2665444, at *1 (S.D.N.Y. Mar. 28, 2023) (finding that courts routinely take judicial notice of records of government agencies).

whose position in the marketplace has been damaged by EmblemHealth's provider directory. They do not compete with EmblemHealth, sell goods or services in competition with health insurance products, or occupy any commercial position that could suffer harm cognizable under Section 43(a) of the Lanham Act. And the Association Plaintiffs cannot assert claims on their Association Members' behalf because those Association Members also have not alleged a commercial injury and, in any event, would be necessary participants in any such claim. Thus, the federal claims fail, and this Court lacks subject matter jurisdiction.

Second, because the federal claims must be dismissed for lack of standing, the Court should decline to exercise supplemental jurisdiction over the state law claims. But the Court need not rely solely on principles of comity—the Class Action Fairness Act of 2005 independently requires abstention with respect to the New York state claims under the "home state controversy exception," which, in an effort to curb forum shopping, requires federal courts to decline to exercise jurisdiction where two-thirds or more of the proposed class and the primary defendant(s) are citizens of the state where the action is filed. Plaintiffs' allegations show that the threshold for this exception is met. Moreover, New York law prohibits class action plaintiffs from seeking statutory damages, which the Plan Member Plaintiffs seek here as an end-run around New York state procedural law. In short, the state law claims are barred at every turn—by comity, by statute, and by the very rules Plaintiffs sought to evade by filing here.

Third, all of Plaintiffs' federal and state law claims fail because no reasonable consumer would be deceived by EmblemHealth's provider directory. The Complaint itself defeats Plaintiffs' theory: it acknowledges that the "Find a provider" tool includes a disclaimer stating that provider information is self-reported and verified only at initial credentialing and every three years thereafter. The Complaint further concedes that certain alleged "inaccuracies," such as duplicate

listings, are "immediately and obviously apparent to anyone who utilizes the provider directory." Compl. ¶ 152. No reasonable consumer viewing a database with these disclosed limitations would understand it as a warranty of real-time availability.

Fourth, and finally, this lawsuit would be a complete waste of judicial resources as the AOD provides all available relief for every alleged harm, rendering this litigation unnecessary before it began.

The Complaint should be dismissed in its entirety.

II. FACTUAL BACKGROUND

A. The Parties

Defendant EmblemHealth, Inc. is a New York not-for-profit corporation that offers health plans to New York consumers and serves over three million individuals in the state. Compl. ¶ 42. Defendant EmblemHealth Plan, Inc. (formerly Group Health Incorporated, or "GHI") is a New York State not-for-profit health insurer and wholly-owned subsidiary of EmblemHealth, Inc. Compl. ¶ 28. EmblemHealth offers both "fully-insured" and "self-funded" insurance plans, and serves as a third-party administrator for numerous employers, including the City of New York. Compl. ¶¶ 43-44.

The City of New York offers its 1.25 million employees and retired employees a choice among ten health insurance plans, and for many years hired EmblemHealth to administer health insurance benefits through the GHI Comprehensive Benefits Plan ("GHI CBP").[2] Compl. ¶ 44. GHI CBP had the highest enrollment of any health plan offered to City employees, with approximately 60 percent of the City's workforce selecting GHI CBP, resulting in approximately

[2] The GHI CBP was a preferred provider organization plan administered by EmblemHealth through 2025. As of January 1, 2026, all GHI CBP Plan Members were automatically re-enrolled into the NYCE preferred provider organization plan.

750,000 Plan Members as of 2025. Compl. ¶ 45. GHI CBP was a preferred provider organization ("PPO") plan in which EmblemHealth contracted with providers and set rates for health care services. Compl. ¶ 48. For Plan Members treated by an in-network mental health provider on an outpatient basis, the cost is a $15 co-pay per visit, with no deductible. Compl. ¶ 48. Plan Members who saw out-of-network providers are subjected to additional costs, including deductibles and payment schedules that use 1983 reimbursement rates. Compl. ¶¶ 49-50.

The Complaint acknowledges that EmblemHealth contracts with Carelon Behavioral Health ("Carelon"), a third-party behavioral health management company, to administer mental health and substance use disorder benefits for GHI CBP Plan Members, including to maintain provider networks for its health plans and make information about participating providers available to Plan Members and consumers through an online provider directory on its public website. Compl. ¶¶ 85-88. Carelon is responsible for credentialing behavioral health providers, maintaining the behavioral health provider network, and managing the accuracy of behavioral health provider information. Compl. ¶ 88.

Plaintiff APA is a national medical specialty society representing psychiatrists and physician members (the "APA Association Members") specializing in the diagnosis and treatment of mental illness, with approximately 39,000 APA Association Members across the United States. Compl. ¶ 16. The APA employs staff dedicated to working on problems of network adequacy and "ghost networks," including conducting "secret shopper" surveys and educating offices of Attorneys General on these issues. Compl. ¶ 17. Plaintiff NYSPA is a district branch of the APA representing psychiatrists in New York, with approximately 3,700 active members (the "NYSPA Association Members," and together with the APA Association Members, the "Association Members"), and dedicates significant resources to legislation aimed at curtailing insurance

practices that inhibit access to care. Compl. ¶¶ 18-19. Neither Association Plaintiff is a commercial enterprise engaged in the sale of goods or services in competition with EmblemHealth or any other health insurer. The Association Plaintiffs expressly disclaim any legal or equitable monetary relief for themselves or their Association Members and seek only equitable and injunctive relief. Compl. ¶ 20. No individual Association Member is a Plaintiff in this case.

The six individual Plan Member Plaintiffs are all members of GHI CBP who allege they or their family members experienced difficulties accessing behavioral health providers. Of the six, five live in the New York City area. Compl. ¶¶ 21-26. Collectively, the Plan Member Plaintiffs claim that they had difficulties searching EmblemHealth's provider directory for mental health providers and/or incurred out of network costs as a result of difficulties using the directory. Compl. ¶¶ 21-26.

B. Plaintiffs' Allegations Regarding the Provider Directory

EmblemHealth's provider directory is a searchable online tool that allows Plan Members to filter providers by specialty, location, and other criteria. According to the Complaint, some providers listed in the directory are not accepting new patients, are no longer in network, have incorrect phone numbers, or are listed at incorrect addresses. Compl. ¶¶ 59-79. Citing the results of a "secret shopper" survey, the Complaint also alleges that the directory contains both ghost listings and duplicate listings that make the network appear larger than it actually is. Compl. ¶¶ 56, 78-79. According to the Complaint, when searching for a mental health provider with "New York, NY" as the location and a 200-mile radius, there are over 1,000 listings referencing only 50 actual providers. Compl. ¶ 62. Citing prior AODs, the Complaint alleges that the alleged directory inaccuracies are longstanding. Compl. ¶¶ 51-55.

The Complaint states that EmblemHealth's "Find a provider" tool includes prominent disclaimers informing users that the provider information is self-reported by providers and is

verified only at initial credentialing and every three years thereafter. Compl. ¶¶ 87-88. The Complaint states that these disclaimers appear on the directory and are visible to users when searching for providers. *Id*. The Complaint further explains that certain alleged "inaccuracies," such as duplicate listings for individual providers appearing at multiple addresses, are "immediately and obviously apparent to anyone who utilizes the provider directory." Compl. ¶ 152.

The Complaint alleges that approximately 40 percent of providers listed with "New York, NY" addresses are telehealth-only providers, and that a significant percentage of listings are for providers associated with large institutions or hospital systems. Compl. ¶ 72. The Complaint does not contain any claims or allegations explaining how or why mental care through telehealth is inherently harmful to consumers or not as desirable as conventional, in-person services.

C. Prior Assurances of Discontinuance and Regulatory History

Prior to the filing of this action, the New York Attorney General conducted a comprehensive, years-long investigation into the very same conduct alleged in the Complaint. On February 19, 2026, EmblemHealth entered into the AOD with the New York Attorney General, which addresses every category of harm Plaintiffs allege and provides every form of relief they seek, aside from penalties and attorneys' fees.

The AOD requires EmblemHealth to maintain an accurate online provider directory with specified data fields, including: provider name, address, telephone number, licensure, digital contact information; whether the provider is accepting new patients; for mental health and substance use disorder providers, any affiliations with facilities certified by the Office of Mental Health or Office of Addiction Services and Supports; any restrictions regarding the availability of the provider's services, including age limitations or specific conditions treated; languages spoken; and for physicians, board certification and hospital affiliations. Ex. B ¶ 78.

The AOD further requires EmblemHealth to: verify every behavioral health provider's information every ninety days through outreach by electronic means, fax, or U.S. mail; correct directory listings within two business days of learning of any changes; remove providers who fail to verify their information within fifteen days of a verification cycle; respond to Plan Member inquiries within one business day; and hold Plan Members harmless (responsible only for in-network cost-sharing) when inaccurate network status information is provided. Ex. B ¶¶ 80, 82-84.

The AOD also establishes comprehensive monitoring and oversight through an independent monitor, who will submit biannual compliance reports to the Attorney General assessing EmblemHealth's compliance with directory accuracy, network adequacy, and related requirements. Ex. B ¶¶ 92-103. The independent monitor will monitor the adequacy of EmblemHealth's procedures for verifying provider information, analyze claims data, assess discrepancies in network breadth, and review consumer complaints. *Id*.

The AOD mandates restitution to all Plan Members who paid amounts in excess of in-network cost-sharing for behavioral health services rendered by non-participating providers who were incorrectly listed as participating providers, including interest at twelve percent. Ex. B ¶ 104. EmblemHealth must also pay $2.5 million in penalties, fees, and costs. Ex. B ¶ 109.

In sum, the AOD provides comprehensive relief addressing every form of injunctive, equitable, and monetary relief sought in the Complaint. The alleged harms have been addressed, and relief has been secured, through binding regulatory authority.

D. Plaintiffs' Claims

Plaintiffs assert seven causes of action: (1) violations of Section 43(a)(1)(A) of the Lanham Act, 15 U.S.C. § 1125(a)(1)(A) (unfair competition and false affiliation); (2) violations of Section 43(a)(1)(B) of the Lanham Act, 15 U.S.C. § 1125(a)(1)(B) (false advertising); (3) common law

unfair competition; (4) violations of New York General Business Law ("GBL") § 349; (5) violations of New York GBL § 350; (6) violations of New York Insurance Law § 4226; and (7) unjust enrichment. The Association Plaintiffs expressly disclaim any legal or equitable monetary relief for themselves or their Association Members and seek only equitable and injunctive relief. Compl. ¶ 20.

III. LEGAL STANDARD

On a motion to dismiss under Rule 12(b)(1), the plaintiff bears the burden of establishing subject matter jurisdiction. *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000) (citation omitted). A case is properly dismissed under Rule 12(b)(1) when the district court lacks the statutory or constitutional power to adjudicate it. *Morrison v. Nat'l Australia Bank Ltd.*, 547 F.3d 167, 170 (2d Cir. 2008), *aff'd*, 561 U.S. 247 (2010).

On a motion to dismiss under Rule 12(b)(6), the court must accept as true the factual allegations in the complaint and draw all reasonable inferences in the plaintiff's favor, but it is not "bound to accept as true a legal conclusion couched as a factual allegation." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A complaint must contain "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678 (citation omitted).

IV. ARGUMENT

A. The Association Plaintiffs Lack Standing Under the Lanham Act

The sole basis for this Court's original jurisdiction is the Association Plaintiffs' claims under Section 43(a) of the Lanham Act, which they bring on "behalf of themselves and their

[association] members" Compl. ¶ 20. The Association Plaintiffs, however, lack standing to assert these claims for either party.

1. The Association Plaintiffs Lack Standing to Assert Claims on their Own Behalf

The Association Plaintiffs lack standing to assert claims under Section 43(a) of the Lanham Act because they are not commercial market participants. To establish standing for a false advertising claim under § 1125(a), a plaintiff must "allege an injury to a commercial interest in reputation or sales." *Lexmark International, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 131-32 (2014). In other words, the plaintiff must be "engaged in 'commerce within the control of Congress' whose position in the marketplace has been damaged by [the defendant's] false advertising." *Id*. at 137. The Second Circuit has consistently applied this requirement, holding that Lanham Act plaintiffs must allege injury in the form of "direct diversion of sales or by a lessening of goodwill associated with its products." *Souza v. Exotic Island Enters., Inc.*, 68 F.4th 99, 119 (2d Cir. 2023) (citation omitted).

PharmacyChecker.com v. Nat'l Ass'n of Boards of Pharmacy, 629 F. Supp. 3d 116 (S.D.N.Y. 2022), is directly on point. There, the court dismissed an association's Lanham Act claim because it "failed to allege that it is a market participant, which fatally undermines any claim of injury proximately caused by [defendant's] conduct." *Id*. at 130. The same is true here. The APA and NYSPA are not commercial enterprises with any position in the marketplace. They do not compete with EmblemHealth—directly or indirectly—nor do they sell goods or services in competition with health insurance products. Put simply, they occupy no commercial position that could be "damaged" by EmblemHealth's provider directory. The Association Plaintiffs' individual claims must therefore be dismissed on this basis alone.

2. The Association Plaintiffs Lack Standing to Assert Claims on Behalf of Their Association Members

An association has Article III standing to bring a claim on behalf of the Association Members only when: "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of the individual members in the lawsuit." *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977). The Association Plaintiffs fail to meet this standard.

First, the Association Plaintiffs' Association Members do not have standing to assert the Lanham Act claims. Where, as here, a Lanham Act plaintiff is a non-direct competitor, the complaint must affirmatively plead "actual injury and causation." *Souza v. Exotic Island Enters., Inc.*, 68 F.4th 99, 119 (2d Cir. 2023) (citation omitted). The Complaint alleges three categories of harm, none of which is sufficient to confer Lanham Act standing. *See* Compl. ¶¶ 120-131.

The Association Plaintiffs first claim reputational harm. However, the Complaint fails to allege that the reputational harms caused any consumer to "withhold trade" from the associations or the Association Members—the hallmark of commercial injury under the Lanham Act—or otherwise divert business from either the associations themselves or any Association Member. *See Skillz Platform Inc. v. Papaya Gaming, Ltd.*, No. 24CV1646 (DLC), 2025 WL 3268799, at *4 (S.D.N.Y. Nov. 21, 2025) (citation omitted) (reputational injury flowing from the claimed deception occurs when "deception of consumers causes them to withhold trade from the plaintiff"). This reputational harm is precisely the type of non-commercial injury *Lexmark* and *PharmacyChecker.com* foreclose. Therefore, as alleged, the claimed reputational harms do not satisfy the standing requirements under the Lanham Act.

Next, the harm related to Plaintiffs' reimbursement rate theory fares no better, as it is overly speculative and ignores the complexities inherent in commercial contract negotiations. The Complaint speculates that "*if* EmblemHealth had to offer a real network of mental health providers," it "*would* have to pay providers market rates to participate." Compl. ¶ 129 (emphases added). This kind of speculative, conclusory allegation cannot confer standing. *See Ortho Pharm. Corp. v. Cosprophar, Inc.*, 828 F. Supp. 1114, 1126 (S.D.N.Y. 1993), *aff'd*, 32 F.3d 690 (2d Cir. 1994) (no Lanham Act standing where damages allegations amount to speculation that profits might be greater absent defendant's conduct).

The "administrative burden" allegations—that is, the cost associated with the providers' end of maintaining directory information—similarly do not suffice. These alleged "burdens" are just ordinary costs of market participation that exist regardless of any alleged deception. The Complaint fails to allege that these administrative burdens were proximately caused by Emblem or the claimed directory issues; rather, the allegations state they are the cost "to maintain directory information"—not the cost of correcting any issue that can be traced to Emblem. Compl. ¶ 125; *see Lexmark*, 572 U.S. at 133-34 (plaintiff must show "economic or reputational injury *directly flowing* from the deception") (emphasis added); *Souza,* 68 F.4th at 119 (indirect competitors "must present some affirmative indication" of causation) (citation omitted). Accordingly, because the Complaint does not allege commercial injury to the individual Association Members directly flowing from Emblem's conduct, they lack statutory standing under the Lanham Act.

Second, the Association Plaintiffs lack Article III standing to assert claims on behalf of the Association Members because "the fact and extent of injury would require individualized proof," and "require [] the participation of individual members in the lawsuit." *Bano v. Union Carbide Corp.*, 361 F.3d 696, 714 (2d Cir. 2004). (citations omitted). The Association Plaintiffs fail to

satisfy the third *Hunt* factor for a simple reason: both their claims and the relief they seek demand the participation of individual Association Members.

Directory "inaccuracy" is an inherently individualized inquiry, particularly under the Lanham Act, where the nature of the relief sought is outcome-determinative. *See Bano*, 361 F.3d at 714 ("[W]hether an association has standing to invoke the court's remedial powers on behalf of its members depends in substantial measure on the nature of the relief sought.") (citation omitted). Whether any Association Member's listing is inaccurate turns on that provider's current practice status, office locations, contact information, insurance participation, and specialty designations. These facts differ from provider to provider and demand testimony and evidence from each individual Association Member whose listing is allegedly inaccurate. The Association Plaintiffs cannot establish a pattern of inaccuracy with respect to individual Association Members through generalized proof; rather, each alleged inaccuracy must be examined case by case.

Individual participation by each Association Member is also indispensable because neither the Association Plaintiffs nor their Association Members directly compete with EmblemHealth. That matters: the Lanham Act requires non-direct competitors to prove actual commercial injuries flowing from the challenged conduct. *Souza*, 68 F.4th at 119. Any such injury is necessarily unique to each Association Member's circumstances—how many patients could not reach them, whether those patients sought care elsewhere, and whether the Association Member lost income as a result. These individualized inquiries into harm cannot be resolved through representative litigation. *See, e.g., Bano*, 361 F.3d at 715 (*Hunt's* third prong unsatisfied where "[p]articipation by individual property owners would be needed to permit identification of which properties were contaminated.").

Here, to correct allegedly inaccurate listings, the Court would need to identify which specific information is wrong for each Association Member, determine what the correct information should be, and verify whether each Association Member actually participates in EmblemHealth's network. The associations cannot supply this information because they do not possess the admissible, provider-specific data required to craft an appropriate injunction. Individual Association Member participation is therefore essential. *See Warth v. Seldin*, 422 U.S. 490, 515-16 (1975) (associational standing unavailable where resolution requires individualized proof). Therefore, the APA and NYSPA lack standing to bring Lanham Act claims on behalf of their Association Members.

The Complaint's own allegations confirm this fatal defect. Plaintiffs allege various inaccuracies, including wrong phone numbers, wrong addresses, outdated network participation status, and incorrect availability to new patients. Compl. ¶¶ 59-79. But each of these is inherently provider-specific: one psychiatrist may have moved offices while another left the network entirely; one may have fielded complaints from frustrated patients while another experienced none; one may have changed a phone number while another simply did not answer calls. And whether any Association Member suffered reputational harm—negative reviews from failed appointment attempts, damaged relationships with referring physicians, lost referrals—depends entirely on that Association Member's unique circumstances. No amount of generalized statistical evidence or "secret shopper" surveys can substitute for the individualized proof each Association Member's situation demands.

The conclusion is inescapable: the Association Plaintiffs lack standing, both on their own behalf and on behalf of their Association Members. Thus, the federal claims must be dismissed, and with them, this Court's basis for original jurisdiction. To the extent the Association Members

wish to assert these claims, they must do so in their individual capacities, which they have not done in this case. *See Bano*, 361 F.3d at 715 (association failed to satisfy association standing requirements, which provides "a narrow exception from the ordinary rule that a litigant 'must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties'").

B. The Court Should Decline to Exercise Jurisdiction Over the Putative Class Claims

Because all federal claims should be dismissed, the Court lacks original jurisdiction over this action. This alone is enough for the Court to decline to exercise supplemental jurisdiction over the remaining New York common law and statutory claims (unfair competition, unjust enrichment, N.Y. GBL §§ 349, 350, N.Y. Insurance Law § 4226). *See* 28 U.S.C. § 1367(c)(3) ("district courts may decline to exercise supplemental jurisdiction" if "the district court has dismissed all claims over which it has original jurisdiction"); *Martin v. Sprint United Mgmt. Co.*, No. 15 CIV. 5237 (PAE), 2017 WL 5028621, at *2 (S.D.N.Y. Oct. 31, 2017) ("[I]n the usual case in which all federal-law claims are eliminated before trial, the balance of factors to be considered under the pendent jurisdiction doctrine—judicial economy, convenience, fairness, and comity—will point toward declining to exercise jurisdiction over the remaining state-law claims.") (citing *Sefovic v. Mem'l Sloan Kettering Cancer Ctr.*, No. 15 Civ. 5792 (PAC), 2017 WL 3668845, at *8 (S.D.N.Y. Aug. 23, 2017)); *United Mine Workers of Am. v. Gibbs*, 383 U.S. 715, 726 (1966) ("Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties."). These considerations are especially compelling here, where the New York Attorney General has already addressed every category of harm alleged in the Complaint through the comprehensive AOD. The state regulatory process has provided complete relief, rendering federal court intervention duplicative and unnecessary.

However, even if the Lanham Act claims were to remain in this case (which they should not), the Court should abstain from exercising jurisdiction over the New York state claims under the Class Action Fairness Act of 2005 ("CAFA")—a statute enacted in large part to curb class action forum shopping. 28 U.S.C. § 1332(d)(4)(B). The "home-state controversy exception" under CAFA requires federal courts to decline to exercise jurisdiction where two-thirds or more of the members of the proposed class and the primary defendant(s) are citizens of the state where the action is filed. *See id.*, *Gold v. N.Y. Life Ins. Co.*, 730 F.3d 137, 141 (2d Cir. 2013). Given the nature of the New York statutory and common law claims alleging Plan Member complaints related to the in-state distance from a New York provider (*see* Compl. ¶¶ 71-72, 81), that each named Plan Member Plaintiff is alleged to live in or around New York City (*see* Compl. ¶¶ 21-26), and that EmblemHealth is a New York company (*see* Compl. ¶¶ 27-28), it is evident that this CAFA exception applies. Consequently, the Court must abstain from exercising jurisdiction over the Plan Member Plaintiffs' New York state claims, regardless of the outcome of the Lanham Act claims.

Dismissal of the class claims is further justified because the Plan Member Plaintiffs appear to seek statutory damages in connection with their New York statutory claims, which New York law precludes in the context of a class action. Compl. ¶¶ 142–153 (alleging EmblemHealth's knowledge, a necessary prerequisite for N.Y. Insurance Law § 4226 statutory damages), ¶ 254 (requesting "trebled and punitive damages," available under certain circumstances in connection with NY GBL §§ 349 and 350 claims). Under New York law, "an action to recover a penalty, or minimum measure of recovery created or imposed by statute may not be maintained as a class action" unless the statute "specifically authorizes the recovery thereof in a class action." CPLR 901(b); *see also Sperry v. Crompton Corp.*, 8 N.Y.3d 204, 214 (2007) ("Where a statute is already

designed to foster litigation through an enhanced award, CPLR 901(b) acts to restrict recoveries in class actions absent statutory authorization."); *Borden v. 400 E. 55th St. Assocs., L.P.*, 24 N.Y.3d 382, 394-95 (2014) (recognizing that claim for $50 minimum damages under General Business Law §349(h) could not be brought as a class action). Class members seeking remedies not authorized by statute must opt out of the class. *See, e.g.*, *Downing v. First Lenox Terrace Assoc.*, 107 A.D.3d 86, 89 (1st Dep't 2013), *aff'd sub nom. Borden v. 400 E. 55th St. Assocs., L.P.*, 24 N.Y.3d 382 (2014) ("[E]ven where a statute creates or imposes a penalty, the restriction of CPLR 901(b) is inapplicable where the class representative seeks to recover only actual damages and waives the penalty on behalf of the class, and individual class members are allowed to opt out of the class to pursue their punitive damages claims.").

Unable to pursue statutory penalties as a class in New York state Court, Plaintiffs appear to seek federal court jurisdiction as a workaround, thereby shoehorning Lanham Act claims into a complaint that otherwise revolves exclusively around questions of New York law. This is precisely the type of forum manipulation that CAFA was designed to prevent. The Court should not countenance Plaintiffs' attempts to sidestep these restrictions on remedies imposed by New York law.

Accordingly, the Court should decline to exercise jurisdiction over the New York common law and statutory claims. Beyond principles of comity and statutory requirements, exercising jurisdiction here would serve no practical purpose: the AOD already provides every form of injunctive, equitable, and compensatory relief to which Plaintiffs are entitled. *See infra* at IV.D. Federal judicial resources should not be expended to adjudicate claims where the relief has already been obtained through binding state regulatory action.

C. No Reasonable Consumer Would Have Been Deceived

Regardless of the Court's decision on standing and whether to exercise supplemental jurisdiction over Plaintiffs' state law claims, each of Plaintiffs' claims fails as a matter of law. Under both the Lanham Act and New York GBL §§ 349 and 350, "a court may determine as a matter of law that an allegedly deceptive advertisement would not have misled a reasonable consumer." *Chufen Chen v. Dunkin' Brands, Inc.*, 954 F.3d 492, 500 (2d Cir. 2020) (affirming dismissal).

Here, Plaintiffs' own allegations defeat their claims. The Complaint acknowledges that the "Find a provider" tool includes a disclaimer stating that the information is self-reported by providers and verified only at initial credentialing and every three years. Compl. ¶¶ 87-88. A reasonable consumer viewing a database that discloses these limitations would understand that it is not a warranty of real-time availability. The directory does not represent that every listing is accurate at all times—it expressly disclaims such accuracy. *See Mazella v. Coca-Cola Co.*, 548 F. Supp. 3d 349, 357 (S.D.N.Y. 2021) (disclaimers or similar clarifying language may defeat a claim of deception). Where, as here, a defendant discloses the limitations of its information, consumers are on notice and cannot claim deception. *See Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank, N.A.*, 85 N.Y.2d 20, 26 (1995) (GBL § 349 requires that the challenged act be "likely to mislead a reasonable consumer acting reasonably under the circumstances").

Moreover, certain alleged "inaccuracies" identified in the Complaint are, by Plaintiffs' own admission, "immediately and obviously apparent to anyone who utilizes the provider directory." Compl. ¶ 152. Where purported deficiencies are self-evident, no consumer acting reasonably would be deceived. *See Oswego*, 85 N.Y.2d at 26.

The same analysis applies to Plaintiffs' claims under New York Insurance Law § 4226, which prohibits "misleading" statements by insurers. Given the disclosed limitations of the

directory and the obvious nature of certain alleged inaccuracies, no reasonable insured would have been misled.

Accordingly, the Court can and should determine as a matter of law that EmblemHealth's provider directory, accompanied by its disclaimers and with its self-evident limitations, would not deceive a reasonable consumer. Plaintiffs' causes of action fail to state a claim and should be dismissed. Moreover, even if the Court were to find some theoretical basis for deception, this litigation would be an empty exercise: the AOD has already addressed the alleged directory deficiencies through comprehensive remediation requirements, ongoing verification protocols, and independent monitoring. Any judgment on consumer deception would have no practical effect beyond what the AOD already mandates.

D. Plaintiffs Cannot Obtain Meaningful Relief Beyond the AOD

Plaintiffs' claims should be dismissed because they cannot obtain any meaningful relief beyond what the AOD already provides. This is a fundamental question of judicial utility: where comprehensive relief has already been secured through binding regulatory authority, it would waste judicial resources to adjudicate claims for which all available relief has already been secured.

The AOD addresses every category of harm Plaintiffs allege and provides every form of relief they seek. As detailed above, the AOD requires EmblemHealth to:

- Maintain an accurate online provider directory with comprehensive data fields;
- Verify every behavioral health provider's information every ninety days;
- Correct directory listings within two business days of learning of changes;
- Remove non-responsive providers within fifteen days of a verification cycle;
- Respond to Plan Member inquiries within one business day;
- Hold Plan Members harmless when inaccurate network status information is provided;

- Pay restitution to all affected Plan Members with twelve percent interest;
- Pay $2.5 million in penalties, fees, and costs; and
- Submit to oversight by an independent monitor for at least three years.

Ex. B ¶¶ 78-104, 109. This is precisely the relief Plaintiffs seek. The Complaint demands injunctive relief requiring EmblemHealth to maintain an accurate directory, verify provider information, correct errors promptly, and compensate affected consumers—all of which the AOD already mandates. Implementation of the AOD's remediation requirements is already well underway. *See, e.g.*, Ex. B ¶¶ 82-88 (requiring EmblemHealth to submit various policies and procedures designed to achieve compliance with the AOD within 30 days of the AOD's Effective Date). Any judgment this Court could enter would simply duplicate the binding obligations EmblemHealth has already assumed.

Courts routinely dismiss claims where plaintiffs have already received the relief they seek through parallel regulatory action. *See, e.g.*, *Charlton v. LG Energy Sol. Michigan, Inc.*, No. 321CV02142RBMJLB, 2023 WL 1420726, at *4-*5 (S.D. Cal. Jan. 31, 2023) (claims dismissed where product recall pursuant to regulator program provided complete relief); *Sugasawara v. Ford Motor Co.*, No. 18-CV-06159-LHK, 2019 WL 3945105, at *6 (N.D. Cal. Aug. 21, 2019) (claims dismissed where defendant entered into "statutorily mandated and administratively overseen national recall process" subject to continued regulatory oversight) (citation omitted); *see also Kommer v. Ford Motor Co.*, No. 1:17-CV-296 (LEK/DJS), 2017 WL 3251598, at *5 (N.D.N.Y. July 28, 2017) ("[Plaintiff] has not suffered an injury if the defect can be repaired for free") (citation omitted). Here, EmblemHealth's conduct is subject to binding legal compulsion under the AOD, with significant monetary penalties for non-compliance and oversight by an independent

monitor. Ex. B ¶¶ 92-103, 107, 110. The regulatory process has achieved what Plaintiffs' lawsuit seeks to accomplish.

Because the AOD provides comprehensive prospective injunctive relief, ongoing monitoring, and restitution to affected Plan Members, Plaintiffs cannot identify any additional relief this Court could provide and to which it is entitled under the law. Proceeding with this litigation would waste judicial resources to adjudicate claims for which relief has already been secured. The Complaint should be dismissed.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court grant the Motion to Dismiss the Complaint in its entirety. The Association Plaintiffs lack standing under the Lanham Act, the Court should decline to exercise jurisdiction over the Plan Member Plaintiffs' claims, the consumer deception claims fail as a matter of law, and Plaintiffs cannot obtain any meaningful relief beyond what the AOD already provides.

Dated: April 3, 2026
New York, New York

Respectfully Submitted,

PILLSBURY WINTHROP SHAW PITTMAN LLP

By: _*/s/ Amanda H. Freyre*_____

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CERTIFICATE OF SERVICE

I hereby certify that on this date, the foregoing Memorandum of Law in Support of Defendants' Motion to Dismiss was filed with the Court via the Court's CM/ECF system, which will provide electronic notification to all counsel of record.

Dated: April 3, 2026

/s/ Amanda H. Freyre
Amanda H. Freyre

Counsel for Defendants EmblemHealth, Inc., and EmblemHealth Plan, Inc.

CERTIFICATE OF COMPLIANCE

I, Amanda H. Freyre, an attorney duly admitted to practice before this Court , hereby certify pursuant to Local Rule 7.1(c) of the United States District Courts for the Southern and Eastern Districts of New York (the "Local Rules") and Rule 3(D) of Judge John G. Koeltl's Individual Rules and Practices in Civil Cases (the "Individual Rules"), that the foregoing Memorandum of Law was prepared using Microsoft Word, contains 5760 words in accordance with the Local and Individual Rules, and otherwise complies with the formatting requirements specified in the Local and Individual Rules. In making this calculation, I have relied on the word count of the word-processing program used to prepare the document.

Dated: April 3, 2026

/s/ Amanda H. Freyre
Amanda H. Freyre

Counsel for Defendants EmblemHealth, Inc., and EmblemHealth Plan, Inc.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

THE AMERICAN PSYCHIATRIC ASSOCIATION, THE NEW YORK STATE PSYCHIATRIC ASSOCIATION, on their behalf and in an associational capacity on behalf of their members, and MILEN BEYENE, VALERIA CALDERON, ELIZABETH CANTY, BONNIE DORIS ELLIOTT, DANIEL RICCOBONO, and NIMROD SHIMRONY, on behalf of themselves and all others similarly situated, Plaintiffs, v. EMBLEMHEALTH, INC. and EMBLEMHEALTH PLAN, INC., Defendants.	Case No. 1:25-cv-10783-JGK Hon. John G. Koeltl

DECLARATION OF AMANDA H. FREYRE IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

Pursuant to 28 U.S.C. § 1746, Amanda H. Freyre, declares as follows:

1. I am a partner in the law firm of Pillsbury Winthrop Shaw Pittman LLP, attorneys for Defendants EmblemHealth, Inc. and EmblemHealth Plan, Inc. I make this Declaration of my own personal knowledge, and if called to testify would testify consistent with the statements herein.

2. I submit this Declaration, and the materials attached hereto, in support of Defendants' Motion to Dismiss Plaintiffs' Complaint.

3. I am aware that the New York Attorney General maintains a database of its enforcement actions which it makes available to the public on its website, https://ag.ny.gov/libraries-documents/advocacy-and-enforcement-actions?page=1.

3. A true and correct copy of a screenshot from the New York Attorney General's website showing that the Assurance of Discontinuance referenced in Defendants' Motion to Dismiss is publicly available on that site is attached hereto as Exhibit A.

4. A true and correct copy of the Assurance of Discontinuance referenced in Defendants' Motion to Dismiss is attached hereto as Exhibit B.

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

Executed on: April 3, 2026

By: */s/ Amanda H. Freyre*
Amanda H. Freyre

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this 3rd day of April 2026.

/s/ Amanda H. Freyre
Amanda H. Freyre

Exhibit A

Letitia James
New York State Attorney General

Advocacy and Enforcement

Filter Advocacy and Enforcement Results

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Enter search terms

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Bureau

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Date

Starting date

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Date: 02-25-2026 **Bureau:** Economic Justice, Internet & Technology (BIT)
Type: Court Filing

New York v. Valve Corporation - Complaint - 2026

View/download document

Date: 02-24-2026 **Bureau:** Executive **Type:** Amicus Curiae

United States of America v. City of New York, et al. - Amicus Brief - 2026

View/download document

Date: 02-19-2026 **Bureau:** Social Justice, Health Care (HCB)
Type: Settlements & Agreements

EmblemHealth, Inc. - Assurance of Discontinuance - 2026

View/download document

Date: 02-18-2026 **Bureau:** Executive **Type:** Court Filing

Exhibit B

ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

In the Matter of

Assurance No. 24-009

Investigation by LETITIA JAMES,
Attorney General of the State of New York, of

EmblemHealth, Inc., EmblemHealth Plan, Inc.,
Health Insurance Plan of Greater New York, and
EmblemHealth Insurance Company,

Respondents.

ASSURANCE OF DISCONTINUANCE

The Office of the Attorney General of the State of New York ("OAG") commenced an investigation pursuant to New York Executive Law § 63(12) into the business practices of EmblemHealth, Inc., EmblemHealth Plan, Inc. f/k/a Group Health Incorporated, Health Insurance Plan of Greater New York d/b/a HIP Health Maintenance Organization, and EmblemHealth Insurance Company f/k/a HIP Insurance Company of New York (collectively, "Respondents" or "Emblem"). OAG's investigation, which is based on its statewide secret shopper survey of thirteen health plans ("Secret Shopper Study"), concerns the accuracy of Respondents' participating provider directory (in particular for behavioral health), the adequacy of their networks of behavioral health providers, and their compliance with behavioral health parity laws. This Assurance of Discontinuance ("Assurance") contains the findings of OAG's investigation and the relief agreed to by OAG and Respondents (collectively, the "Parties"), whether acting through their respective directors, officers, employees, representatives, agents, delegated entities, affiliates, or subsidiaries.

FINDINGS

1. EmblemHealth, Inc., a New York not-for-profit corporation, was formed in 2006 by the merger of Group Health Incorporated and the Health Insurance Plan of Greater New York d/b/a HIP Health Maintenance Organization ("HIP") and offers health plans to New York consumers. EmblemHealth, Inc.'s principal offices are located at 55 Water Street, New York, New York 10041.

2. HIP, a subsidiary of EmblemHealth, Inc., is a New York not-for-profit health insurer and health maintenance organization ("HMO") licensed under Article 43 of the New York Insurance Law and Article 44 of the New York Public Health Law. Its principal offices are located at 55 Water Street, New York, New York 10041.

3. EmblemHealth Plan, Inc., f/k/a Group Health Incorporated ("EHPI"), a subsidiary of HIP, is a New York State not-for-profit health insurer licensed under Article 43 of the New York State Insurance Law. EHPI's principal offices are located at 55 Water Street, New York, New York 10041.

4. EmblemHealth Insurance Company f/k/a HIP Insurance Company of New York ("EHIC"), a subsidiary of HIP Holdings, Inc. (which is a subsidiary of HIP), is licensed under Article 42 of the New York Insurance Law.

5. In the regular course of business, Respondents enroll consumers in health plans and contract with health care providers for the delivery of health care services to those consumers.

THE BEHAVIORAL HEALTH CRISIS IN NEW YORK STATE

6. Three million adult New Yorkers — one in five across the state — live with behavioral disorders.[1] As used in this Assurance, "behavioral health" includes mental health disorders, substance use disorders, and autism. In February 2023, 31 percent of New Yorkers reported symptoms of anxiety or depression.[2] The COVID-19 pandemic dramatically increased the need for behavioral health services in New York.[3]

7. Access to behavioral health treatment remains out of reach for many. More than half of insured adults who do not get needed behavioral health treatment cite lack of coverage by their health plans as the reason.[4] In 2022, almost 500,000 New York children aged 3 through 17 had a diagnosed behavioral health condition (depression, anxiety problems, or behavioral or conduct problems).[5] Of those children, 196,000 (40 percent) did not receive treatment or counseling.[6]

8. Consumers depend on their health insurance to access and afford behavioral health treatment for themselves and their dependents. To find in-network treatment and to shop for insurance, consumers look to provider directories published by health plans. But consumers

[1] Kaiser Family Found. (KFF), *New York: Mental Health & Substance Abuse*, https://www.kff.org/state-category/mental- health/?state=NY (2,972,000 (19.5 percent) adults in New York reported mental illness from 2018-19).
[2] Kaiser Family Found. (KFF), *Mental Health in New York*, https://www.kff.org/statedata/mental-health-and-substance- use-state-fact-sheets/new-york.
[3] *See* N.Y. State Health Found., *Mental Health Impact of the Coronavirus Pandemic in New York State* (2021), https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf; NYC Dep't of Health and Mental Hygiene, *Impacts of COVID-19 on Mental Health in New York City*, 2021 (2021), https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf.
[4] Kaiser Family Found. (KFF), *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance* (Sept. 29, 2023), https://www.kff.org/mental-health/issue-brief/proposed-mental-health-parity-rule- signals-new-focus-on-outcome-data-as-tool-to-assess-compliance/.
[5] Child and Adolescent Health Measurement Initiative, *2022 National Survey of Children's Health*, https://www.childhealthdata.org/browse/survey/results?q=10029&r=34.
[6] *Id.*

— in particular those with behavioral health conditions — may experience challenges when using these directories, including providers not accepting new patients, long wait times to see providers, and inaccurate or out-of-date provider information.

9. Secret shopper surveys, in which callers simulate the experience of consumers calling providers in a plan's network directory, are an effective tool to test directory accuracy and identify gaps in network adequacy. Numerous secret shopper studies conducted during the past eight years have indicated that inaccuracies in health plans' provider directory listings for behavioral health providers exist, including incorrect information about network status, location, and availability to accept new patients.[7] In July 2024, a study published in the Journal of the American Medical Association showed that only 18 percent of mental health clinicians listed as in-network for Medicaid plans were reachable, accepted Medicaid, and could provide a new patient appointment.[8] These are referred to as "ghost networks" — i.e., providers who are listed in a provider directory as being in-network but are not taking new patients or no longer in a plan's network. Other tools serve a similar purpose as secret shopper surveys, including examining claims data to assess whether consumers actually access treatment.

[7] In 2017, a survey of BlueCross BlueShield plans in five cities found that mental health appointments for children were obtained with only 40% of the pediatricians and 17% of the child psychiatrists. Shireen Cama et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, 47 Int'l J. Health Servs. 621, 630 (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/. A different study of BlueCross BlueShield plans in three cities found that mental health appointments with psychiatrists were obtained with only 26% of psychiatrists. Monica Malowney et al., *Availability of Outpatient Care from Psychiatrists: A Simulated-Patient Study in Three U.S. Cities*, 66 Psychiatr. Serv. 94, 95 (2015), https://pubmed.ncbi.nlm.nih.gov/25322445/. And a study of three health plans' directories in the Washington, D.C. area found that only seven percent of psychiatrists offered an appointment within two weeks. Benzion Blech et al., *Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C.*, 68 Psychiatr. Serv. 962, 964 (2017), https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201600454.

[8] Diksha Brahmbhatt & William Schpero, *Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities*, *JAMA*, 332(8):668–669 (2024), https://jamanetwork.com/journals/jama/fullarticle/2821639.

OAG'S INVESTIGATION OF RESPONDENTS

Respondents' Online Participating Provider Directory

10. Respondents operate as a corporation licensed under Article 43 of the New York Insurance Law and as an HMO licensed under Article 44 of the New York Public Health Law. Respondents offer preferred provider organization, health maintenance organization, Essential Plan, Medicaid Managed Care, and Child Health Plus plans.

11. Respondents make available networks composed of various types of behavioral health providers and facilities in New York ("Participating Providers") that accept negotiated rates plus the applicable member co-payment, coinsurance, and/or deductible as payment in full for covered services rendered to the members of Respondents' plans ("Members").

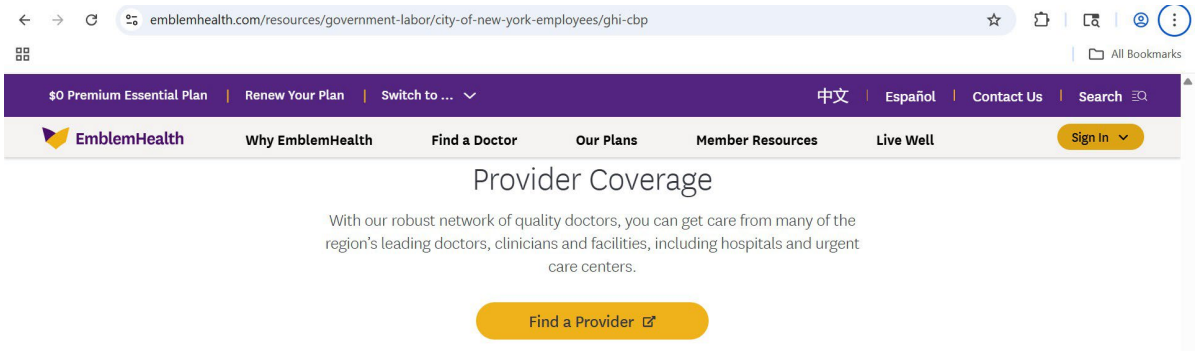
12. As of the Effective Date, Respondents have approximately 1.5 million members in their commercial health plans, New York City employee health plans, Essential Plan products, Qualified Health Plans, Medicaid managed care plans, and Child Health Plus plans.

13. Respondents are legally responsible for maintaining an accurate directory of behavioral health providers, an adequate network of behavioral health providers, and for compliance with behavioral health parity laws. For approximately twenty years, Respondents have retained Carelon Behavioral Health, Inc. and its subsidiaries and affiliates, including Carelon Behavioral Health IPA, Inc. ("Carelon," f/k/a Beacon Health Options, f/k/a Value Options), as a delegated vendor for behavioral health benefit management services to EmblemHealth.

14. Respondents make information about Participating Providers available to Members and other consumers through a provider directory on their public website

www.emblemhealth.com ("Online Participating Provider Directory"), either directly or by clicking a link on a web page that redirects to a web page on Carelon's public website, which features Emblem branding.[9]

15. Respondents encourage Members and other consumers to use their Online Participating Provider Directory. For example, as of the Effective Date, on their public website Respondents inform City of New York employees and their dependents that Respondents have a "robust network of quality doctors" from which Members and other consumers can access care, and instruct them to use Respondents' Online Participating Provider Directory:



16. Respondents' Online Participating Provider Directory contains listings for Participating Providers (including facilities) that include: name, addresses, telephone number(s), and in the case of physicians and other applicable providers, specialty area, hospital affiliations and any applicable board certification, and whether they are accepting new patients.

17. Respondents' Online Participating Provider Directory is available to Members and other consumers who seek information about Respondents' Participating Provider network when selecting their health plans.

[9] https://www.carelonbh.com/emblemhealth/en/home/find-providers.

Respondents' Directory Accuracy Policies and Process

18. In 2010, OAG executed Assurances of Discontinuance with Respondent EmblemHealth Plan Inc., and in 2011, with Respondent Health Insurance Plan of Greater New York, regarding their inaccurate directory listings, including for behavioral health providers (the "2011 AOD"). Respondents agreed to ensure their provider directory is accurate on an ongoing basis. The 2011 AOD is still in effect.

19. In June 2020, a consultant informed Respondents that "[t]here is no functional capability for a provider to attest to the accuracy of their data displayed in the [Online Participating Provider Directory on their website] nor to notify the health plan of any changes that may be required." At some point prior to 2025, Carelon's website allowed Members to report inaccuracies in Online Participating Provider Directory listings.

20. Respondents adopted a policy in January 2021 titled "[Provider Data Validation] Process Overview," which states that, pursuant to the 2011 AOD, Respondents are required to solicit all Participating Providers listed in their Online Participating Provider Directory and in printed provider directories and verify their plan status on at least an annual basis. The policy also states that Respondents use a vendor to validate service locations for providers with whom they contract directly, and "special handling" for other types of providers, and that uncooperative and unresponsive providers may be suppressed (i.e., removed) from the Online Participating Provider Directory.

21. In March 2023, Respondents told the City of New York that Carelon had a "[o]ne- day turnaround time for provider directory updates upon notification of a change in information."

22. Other than audits of small samples of providers that showed many inaccuracies (with a two-time exception where a larger pool was audited and also showed many inaccuracies), Respondents' only other method of ensuring the accuracy of Online Participating Provider Directory listings has been to send notices to providers reminding them to verify their information. But Respondents failed to ensure that Carelon sent these notices to every provider on a regular schedule, as was required by Respondents' own policies and federal law. Respondents did not monitor its behavioral health Online Participating Provider Directory processes after 2020, which Respondents' corporate representative testified was "a lost opportunity." In December 2023, one week after OAG published its Secret Shopper Study, an executive of an affiliate of Respondents suggested that Respondents were "out of compliance" with federal directory accuracy requirements.

23. Respondents' corporate representative also testified that there is "a heavy reluctance to remove a provider from the directory,"—a reluctance which Respondents failed to rectify—and that having accurate listings means removing some providers from the Online Participating Provider Directory and having a less robust network, which is a concern for Respondents.

24. Since 2019, Respondents have removed from their Online Participating Provider Directory some medical/surgical Participating Providers who did not verify their provider directory information, or who did not treat Members within the prior year. However, Respondents did not systematically remove behavioral health Participating Providers from their Online Participating Provider Directory due to failure to verify their information until 2025, and only if such providers did not verify their information for more than one year.

25. Respondents' Online Participating Provider Directory (which includes listings for

certain mental health Participating Providers) does not allow Members, other consumers, or providers to report inaccurate provider information directly on pages containing providers' listings. Rather, they must call Respondents and report errors to the service center.

Respondents' Network Adequacy Policies and Process

26. Respondents' "Network Adequacy Standards - Practitioner" policy requires its provider network to meet or exceed the following availability standards for behavioral health appointment waiting times:

a. Emergencies: member must be seen immediately.

b. Non-life threatening emergent: member must be offered the opportunity to be seen within six hours of the request.

c. Urgent: member must be offered the opportunity to be seen within 48 hours of the request.

d. Initial visit for routine care: member must be offered the opportunity to be seen within ten (10) business days.

e. Follow-up Routine: member must be offered the opportunity to be seen within ten (10) business days.

Respondents' "standard of performance" is that its network has 95 percent or greater availability across all licensure types.

27. Respondents' "Monitoring Access & Appointment Availability" policy sets forth requirements for assessing compliance with Respondents' appointment wait time standards for medical/surgical and behavioral health services, as measured through telephone surveys. For practitioners, an appointment must be scheduled within the appointment availability standards. The policy requires at least 75 percent of the practitioners in Respondents' network to meet the

appointment availability standards. The policy deems the following telephone survey results to be "non-compliant" with the appointment availability standards: no answer after three calls, line busy on three attempts, put on hold for more than 10 minutes in three attempts, disconnected phone, telephone number changed but no forwarding number given, practitioner no longer at number, practitioner no longer participating, and practitioner not accepting new patients.

28. Respondents have not consistently monitored network adequacy for behavioral health services beyond reports that rely on directory listings (which may be inaccurate) and do not measure actual access to providers. In October 2022, a senior compliance executive stated that "[t]here is an open question at [Respondents] attempting to identify who oversees" network adequacy for behavioral health. In late December 2023 (three weeks after OAG published its Secret Shopper Study), another senior compliance executive asked a senior executive, "WHO at EMBLEM monitors the network adequacy assessments that Carelon performs and their results?" Another senior executive responded with a question: "do we get the report so we are responsible?"

OAG's Secret Shopper Study

29. Using a methodology commonly used in academic studies published in peer reviewed journals,[10] OAG conducted a "simulated patient" secret shopper study of behavioral health Participating Providers listed in Respondents' Online Participating Provider Directory,

[10] *See, e.g.*, Diksha Brahmbhatt & William Schpero, *Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities*, *JAMA*, 332(8):668–669 (2024), https://jamanetwork.com/journals/jama/fullarticle/2821639; Shireen Cama et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, 47 Int'l J. Health Servs. 621, 630 (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/; Benzion Blech et al., *Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C.*, 68 Psychiatr. Serv. 962, 964 (2017), https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201600454; Monica Malowney et al., *Availability of Outpatient Care from Psychiatrists: A Simulated-Patient Study in Three U.S. Cities*, 66 Psychiatr. Serv. 94, 95 (2015), https://pubmed.ncbi.nlm.nih.gov/25322445/.

between March 14 and April 27, 2023, and published the results on December 7, 2023.[11] OAG called 44 Participating Providers in New York City listed in Respondents' Online Participating Provider Directory as accepting new patients, including psychiatrists, nurse practitioners, doctoral-level psychologists, and Licensed Clinical Social Workers.

30. OAG called providers posing as a family member of a Member with a mental health need, with the goal of securing an appointment. For two-thirds of the calls, staff used Scenario A (a fictional adult patient), stating the family member is depressed and their primary care physician suggested they see a mental health provider. For one-third of the calls, staff used Scenario B (a fictional child patient), stating they are the parent of a 14-year-old who has begun having problems in school. When callers reached a voicemail, they left a message with a request for a call back. When the listed phone number was incorrect but callers reached a person who could direct them to another number, the caller followed those instructions and attempted to reach the listed provider.

31. Of the 44 Participating Providers listed as accepting new patients in Respondents' Online Participating Provider Directory whom OAG attempted to contact, the Secret Shopper Study found that 16 (36 percent) were not accepting new patients, 11 (25 percent) were not practicing, and five (11 percent) were non-working numbers, incorrect numbers, or unreturned calls. Staff could make appointments with only eight (18 percent) of the listings, either in-person or via telehealth. The Study concluded that 82 percent of the listed providers staff attempted to contact were therefore "ghosts," because, for example, they were unreachable, not accepting new patients, or not in-network — despite being listed in Respondents' directory as in-network and

[11] Office of the New York State Attorney General (Dec. 7. 2023), *Inaccurate and inadequate: Health plans' mental health provider network directories*, https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf, at 17-23.

accepting new patients. The following chart shows detailed results of the Study:

Plan: EmblemHealth | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	28	9	3	3	11%	89%
Scenario B (child)	16	9	5	2	31%	69%
EmblemHealth totals	**44**	**18**	**8**	**5**	**18%**	**82%**

32. Of the 44 Participating Providers OAG contacted, Respondents' data show that they failed to verify the information of 16 of those 44 providers within at least one quarter of the prior year – more than one-third. Respondents' claims data show that of those 44 providers, seven treated no Members in the prior year, and 20 (almost half) treated four Members or less.

33. Respondents have not corrected certain listings of providers whom OAG contacted. For example, in 2023, Respondents' Online Participating Provider Directory listed a provider as accepting new patients and practicing child psychiatry. When OAG called the doctor's office to book an appointment for a child, the receptionist said that the provider works in a nursing home, does not accept outpatient clients, and only sees patients over age 18. Yet until late September and October 2025 (when the provider's listings for four locations were removed), he was still listed as accepting new patients and practicing child psychiatry, even though he submitted no claims to Respondents from 2019 through 2024, and his provider verification file indicates that he lives in Florida and sees patients at eight locations in four different states (Florida, New York, Pennsylvania, and California), in practices whose names include the word "senior." Respondents' corporate representative testified that these facts are "of high concern" and require "a deeper understanding."

Other State Secret Shopper Surveys

34. In secret shopper surveys, the New York State Department of Health ("DOH")

also found serious deficiencies in Respondents' Online Participating Provider Directory. In 2020, DOH called 60 Medicaid providers in Respondents' network and found a 33 percent participation rate and 67 percent directory inaccuracy rate. In 2023, DOH surveyed primary care providers in Respondents' HIP network, finding that only 45 percent were able to offer timely appointments for routine visits. Also in 2023, a DOH secret shopper survey of Respondents' Essential Plan providers showed that the overall access rate was 49 percent, and that of 30 behavioral health providers surveyed, the access rate was 13 percent.

Respondents' Directory Accuracy and Network Adequacy Audits

35. Respondents' own email audits and secret shopper surveys of behavioral health providers in its Online Participating Provider Directory have produced results similar to OAG's and DOH's findings.

36. Respondents' audit of provider directory data validation for January through July 2022 showed that 23 percent of medical/surgical Participating Provider offices did not respond to requests for data validation. Of Participating Providers who responded, 71 percent reported incorrect location and other errors in their listings.

37. Respondents' audit of provider directory data validation for the second quarter of 2024 showed that 15 percent of medical/surgical Participating Provider offices did not respond to requests for data validation. Of Participating Providers who responded, 60 percent reported incorrect location and other errors in their listings.

38. In January 2025, Respondents called 600 behavioral health Participating Providers seeking to schedule appointments, to "simulate the experience of a member seeking behavioral health services by a practitioner." A secret shopper report issued by Respondents states that only 62 percent of providers surveyed were accepting new patients and only 46

percent had appointment availability within ten days. Respondents' corporate representative testified that the 46 percent figure does not meet Respondents' availability and access standards. Respondents' corporate representative also testified that in calculating these percentages, Respondents excluded providers who could not be reached, but should have included them. Respondents' corporate representative further testified that had Respondents included unsuccessful calls in the result calculations, as required by Respondents' Monitoring Access & Appointment Availability policy (described in Paragraph 27 above), the overall appointment availability would have been 22 percent and the ten-day appointment availability rate would have been 10 percent. These results show Respondents falling far short in meeting the access and availability standards set forth in their own policies.

39. A report prepared by Carelon regarding Respondents' behavioral health Participating Providers confirms an eight percent success rate in calls attempting to schedule appointments with those providers – and that Respondents have a "Ghost network."

40. Thousands of behavioral health providers listed in Respondents' Online Participating Provider Directory do not treat Respondents' Members. During a six-year period from 2019 through 2024, 6,475 of Respondents' behavioral health Participating Providers did not file a single behavioral health claim for treatment of a Member; 4,495 filed no claims at all. In 2023, 87 percent of Respondents' Essential Plan behavioral health Participating Providers were unavailable (defined as filing no claims), as reflected in Respondents' own analysis of their claims data:

Provider Type	Listed	Accessed	Unavailable	Total
Psychiatrist	881	160	721	881
Psychologist	977	114	863	977
Licensed Social Worker	2124	317	1807	2124
Mental Health Counselor	578	46	532	578
Licensed Behavior Analyst	489	0	489	489
Other Mental Health Provider	579	110	469	579
All Providers (Total)	5628	747	4881	5628

Complaints by Respondents' Members Regarding Access to Behavioral Health Treatment

41. From 2018 through 2024, Members of Respondents' health plans lodged at least 360 complaints with Respondents relating to directory inaccuracy or inability to secure behavioral health treatment with Participating Providers.

42. Respondents oversaw and failed to address Carelon's practice of deeming complaints unsubstantiated, even when members unsuccessfully tried to reach providers whose numbers Respondents had given them. For example, a Member contacted Respondents because they could not locate a Participating Provider for their spouse. The member reported that they called at least eight Participating Providers listed in Respondents' Online Participating Provider Directory seeking an appointment for their spouse to see a psychiatrist, but each call was unsuccessful because the provider did not participate with Respondents, was not accepting new patients, or had an incorrect number or place of business. Carelon then gave the spouse a list of approximately twenty-five (25) Participating Providers listed in Respondents' Online Participating Provider Directory, and the spouse called each of them without any success in securing an appointment for the Member. Carelon then reached out to an additional thirty-eight (38) Participating Providers listed in their Online Participating Provider Directory, but could not secure an appointment for the Member's spouse with any of them. Nevertheless, Carelon sent the Member a complaint determination letter stating the complaint was unsubstantiated because the

Member did not send the names of specific providers they called within ten days of the date of the complaint acknowledgement letter. Respondents' corporate representative testified that this outcome was "highly frustrating" due to the Member's lack of access.

43. Another Member filed a complaint with OAG after Carelon failed to respond adequately to her complaint to Respondents regarding her difficulty finding an in-network psychiatrist for her 14-year-old son, who suffered from major depression and attention-deficit disorder. As set forth in OAG's Secret Shopper Study, Respondents "gave her a list of eight in-network providers, but none accepted new patients[.]" Respondents sent the same list of providers to OAG, suggesting they were available in-network providers, despite the fact that the member's out-of-network provider had filed a written grievance with Respondents a month earlier, stating that he called ***the same providers***, who told him they could not treat the member. After Respondents accepted that no Participating Provider could treat the patient and agreed to enter into a single-case agreement with an out-of-network psychiatrist, Respondents asserted to OAG that the provider had requested an "exorbitant" reimbursement rate, when in fact the provider had requested usual, customary, and reasonable rates.

The Harms Caused by Inaccurate Provider Directories

44. Inaccurate provider directories may cause consumers seeking health care to expend additional time and resources combing through website listings and calling providers' offices to secure an appointment with an in-network provider. Ghost networks can exacerbate behavioral health conditions, creating additional anxiety and feelings of hopelessness for patients, who may delay or forego care altogether due to the difficulty of accessing services, the cost, or

both.[12]

45. Surveys consistently show that lack of adequate insurance coverage is a major reason why consumers with behavioral health conditions go without treatment. According to a 2022 survey conducted by The Harris Poll, 43 percent of Americans who needed mental health or substance use-related care in the past year did not receive it, compared to only 21 percent of those who needed primary care.[13] Notably, 43 percent of those who did not receive necessary mental health care in the past year cited insurance-related issues as the barrier and 37 percent reported that cost-related issues prevented them from accessing care.[14]

46. Inaccurate provider directories — and the resultant inability to find in-network providers — lead many consumers to seek out-of-network care.[15] A study analyzing health insurance claims data showed large disparities in out-of-network provider use between behavioral health and physical health services.[16] In New York in 2017, outpatient behavioral health office visits were 10 times more likely than medical/surgical inpatient stays and primary

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[12] John E. Dicken, Gov't Accountability Off., GAO-22-104597, Mental Health Care; Access Challenges for Covered Consumers and Relevant Federal Efforts 12 (2022) ("2022 GAO Report") at 17, https://www.gao.gov/assets/gao-22-104597.pdf; *Barriers to Mental Health Care: Improving Provider Director Accuracy to Reduce the Prevalence of Ghost Networks*¸ U.S. Senate Committee on Finance 2-3 (May 3, 2023) (written testimony of Mary Giliberti, Chief Public Policy Officer, Mental Health America), https://www.finance.senate.gov/imo/media/doc/Mary%20Giliberti-written%20testimony%205-1.pdf; *id.* at 2 (testimony of Robert L. Trestman, PhD, MD On Behalf of the American Psychiatric Association), https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf [hereinafter Trestman Testimony]. *See also* Simon F. Haeder et al., *A Knotty Problem: Consumer Access and the Regulation of Provider Networks*, 44 J. Health Pol. Pol'y L. 937, 938-39 (2019) [hereinafter Haeder et al., *A Knotty Problem*], https://read.dukeupress.edu/jhppl/article-abstract/44/6/937/139734/A-Knotty-Problem-Consumer-Access-and-the?redirectedFrom=fulltext; Simon F. Haeder et al., *Going the Extra Mile? How Provider Network Design Increases Consumer Travel Distance, Particularly for Rural Consumers*, J. Health Pol. Pol'y L. 1107, 1127 (2020) [hereinafter Haeder et al., *Going the Extra Mile?*], https://pubmed.ncbi.nlm.nih.gov/32464649/; Jinkyung Kim et al., *Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care*, 44 Health Serv. Rsch. 145, 156-57 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669622/.

[13] Nat'l Council for Mental Wellbeing, 2022 Access to Care Survey Results, at 4 (May 11, 2022), https://www.thenationalcouncil.org/resources/2022-access-to-care-survey-results/.

[14] *Id.* at 9, 20.

[15] 2022 GAO Report, at 17.

[16] Stoddard Davenport et al., Milliman Research Report, Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement 6 (2019), https://www.milliman.com/en/insight/addiction-and- mental-health-vs-physical-health-widening-disparities-in-network-use-and-p.

care visits to be out-of-network.[17]

47. Many consumers who use out-of-network providers are confronted with surprise bills. In other words, they did not initially know that a provider was out-of-network. In a national survey conducted in 2018, the majority of respondents who had used a mental health provider directory encountered inaccuracies, and as a result of those inaccuracies, were twice as likely as recipients of general medical services to be treated by an out-of-network provider and four times more likely to receive an unexpected outpatient out-of-network bill.[18]

48. Higher out-of-network utilization results in higher costs for consumers. A study of psychotherapy costs between 2007 and 2017 found that out-of-network prices dramatically increased for both adults (from $123.30 to $148.64) and children (from $119.83 to $139.18), even as in-network prices and cost sharing declined.[19] Consumers who lack out-of-network benefits must pay the entire cost of treatment, which is a strong deterrent to seeking care.

49. The harms related to the lack of adequate behavioral health service providers in New York State fall disproportionately on populations that are already marginalized in the health care system.

50. Respondents acknowledge that inaccurate provider directory information impacts their members as follows: (a) "generates confusion and frustration"; (b) "[d]elay in accessing services"; (c) "[r]isk of not obtaining services"; and (d) "[r]isk of unnecessarily utilizing out of network providers."

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[17] *Id*. at 65.

[18] Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 Health Affs. 975, 978-80 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

[19] Nicole M. Benson & Zirui Song, *Prices and Cost Sharing for Psychotherapy In Network Versus Out Of Network In The United States*, 39 Health Affs. 1210, 1212-1213 (July 2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01468. The prices are adjusted to 2016 US dollars.

Disparities between Respondents' Coverage of Behavioral Health Services and Medical/Surgical Services

51. In 2014, after uncovering Respondents' violations of behavioral health parity laws, OAG entered into an Assurance of Discontinuance with EmblemHealth, Inc. (the "2014 AOD") that required it to comply with applicable behavioral health parity laws and other obligations including, among other things, reform its behavioral health review processes and to state in its member handbooks that it provides "broad-based coverage for the diagnosis and treatment of behavioral health conditions, at least equal to the coverage provided for other health conditions." The 2014 AOD is still in effect.

52. Despite the 2014 AOD, Respondents did not have a designated behavioral health parity compliance program until 2020.

53. Respondents enter into "in-network exceptions" for behavioral health services, which allow members to see out-of-network providers at in-network cost sharing due to difficulties finding Participating Providers, at a far greater rate for behavioral health services than for medical/surgical services. For example, in 2022, Respondents' GHI business had 195 Members with in-network exceptions for mental health services, but only eight for medical/surgical services, despite having many times more members receiving medical/surgical services than mental health services. In the second quarter of 2024, Respondents' HIP business had 442 in-network exceptions for mental health services but only 19 for medical/surgical services, despite having many times more members receiving medical/surgical services than mental health services. Such disparities suggest, as has been shown nationally, that Members have difficulties finding Participating Providers at a far greater rate for behavioral health treatment than for medical/surgical treatment.

54. In October 2022, a compliance executive of Respondents enumerated

Respondents' potential parity violations, which included no analysis of provider reimbursement or of usual, reasonable, and customary rates. Respondents have not conducted an analysis of provider reimbursement for purposes of assessing compliance with behavioral health parity laws (described below in Paragraphs 62 through 64), even though conducting such analyses is required by such laws. Since at least the first quarter of 2021, Respondents have possessed data showing that Participating Providers believed Respondents' reimbursement rates for mental health services were low.

LEGAL REQUIREMENTS

Directory Accuracy Requirements for Health Plans

55. New York law requires health plans to include in their provider directories a listing, by specialty, of the name, address, and telephone number of all participating providers, noting whether each provider is accepting new patients. N.Y. Ins. Law §§ 3217-a(a)(17) and 4324(a)(17); N.Y. Pub. Health Law § 4408(1)(r). For mental health and substance use disorder treatment providers, the directories must include any affiliations with participating facilities certified or authorized by the Office of Mental Health ("OMH") or the Office of Addiction Services and Supports ("OASAS"), and any restrictions regarding the availability of the individual provider's services. Insurers must maintain the provider directory on their website and revise it annually, updating the website within 15 days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliations.

56. New York law requires that if a health plan member receives a bill for out-of-network services resulting from inaccurate network status information provided by their health plan, the plan must pay for the services and can charge the member only their in-network cost sharing, regardless of whether the member's coverage includes out-of-network services. N.Y.

Ins. L. §§ 3217-b(n) and 4325(o); N.Y. Pub. Health L. § 4406-c(12); 11 N.Y.C.R.R. § 52.77(a).

57. New York regulations require that "every MCO [managed care organization] shall maintain and update, on a quarterly basis, a listing by specialty of the names, addresses and telephone numbers of all participating providers, including facilities, and in the case of physicians, board certification. Where the MCO contracts with behavioral health facilities rather than directly with behavioral health providers, the provider types available at the facilities must be included in the listing." 10 N.Y.C.R.R. § 98-1.16(i).

58. The federal No Surprises Act requires all private health plans to maintain accurate online provider directories, verify their directories at least every 90 days, and post any changes within two business days. 42 U.S.C. § 300gg-115(a). Plans must apply in-network cost sharing for covered services provided by providers inaccurately listed as in-network. 42 U.S.C. § 300gg-115(b).

Network Adequacy Requirements for Health Plans

59. New York law requires each commercial health insurance plan to "ensure that the[ir] network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract." N.Y. Ins. Law § 3241(a)(1).

60. New York health plans must provide referrals to non-participating providers at in-network cost sharing for members who are unable to access an appropriate participating provider. N.Y. Ins L. §§ 4804(a), 4910(b)(4).

61. Each qualified health plan ("QHP") sold on the New York State of Health Marketplace must maintain a network "that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure

that all services will be accessible without unreasonable delay." 45 C.F.R. § 156.230(a)(1)(ii).

Behavioral Health Parity Requirements for Health Plans

62. The Mental Health Parity and Addiction Equity Act ("MHPAEA") prohibits covered group health plans from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than the treatment limitations they apply to medical/surgical benefits. 42 U.S.C. § 300gg-26. "Treatment limitations" include nonquantitative treatment limitations ("NQTLs"), "which otherwise limit the scope or duration of benefits for treatment under a plan or coverage." NQTLs include "[s]tandards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage." 45 C.F.R. § 146.136(c)(4)(ii). A plan may not impose an NQTL on mental health or substance use disorder benefits unless, "as written and in operation," the NQTL is "comparable to" and "applied no more stringently" than to medical/surgical benefits. 45 C.F.R. § 146.136(c)(4)(i)(A). For example, if a health plan takes steps to ensure it has an adequate number of in-network medical/surgical providers, the plan must take comparable steps to ensure an adequate number of in-network mental health and substance use disorder providers. Plans must also "perform and document comparative analyses of the design and application of NQTLs." 42 U.S.C. § 300gg-26(a)(8)(A).

63. The essential health benefit regulations under the ACA extend MHPAEA's requirements to small and individual plans.

64. New York's behavioral health parity law (originally enacted as "Timothy's Law")

incorporates the requirements of MHPAEA. N.Y. Ins. L. §§ 3216(i)(31), (i)(35); §§ 3221(l)(5), (7); §§ 4303(g), (l).

Health Plans' Obligations to Provide Accurate, Non-Misleading Information

65. New York General Business Law § 349(a) prohibits "deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service" in New York State.

66. New York General Business Law § 350 prohibits false advertising "in the conduct of any business, trade or commerce or in the furnishing of any service" in New York.

67. New York Public Health Law § 4405(10) permits health maintenance organizations to advertise their health care services provided that all information disseminated to the public shall be strictly factual in nature and accurate in all respects and shall not in any way be misleading to the public. New York 10 NYCRR § 98-1.16(i) requires "every MCO [to] maintain and update, on a quarterly basis, a listing by specialty of the names, addresses and telephone numbers of all participating providers, including facilities, and in the case of physicians, board certification. Where the MCO contracts with behavioral health facilities rather than directly with behavioral health providers, the provider types available at the facilities must be included in the listing."

68. New York Insurance Law § 4226 prohibits misrepresentations and misleading statements by insurers.

69. OAG finds that Respondents' actions and omissions are in violation of: New York Executive Law § 63(12); Insurance Law §§ 3217-a(a)(17), 4324(a)(17), 3241(a)(1), 3216(i)(31) & (35), 3221(l)(5) & (7), 4303(g) & (l), and 4226; Public Health Law §§ 4408(1)(r) and 4405(10); General Business Law §§ 349(a) and 350; 10 N.Y.C.R.R. § 98-1.16(i); 42 U.S.C. §§

300gg-115(a) and 300gg-26; and 45 C.F.R. §§ 146.136(c) and 156.230(a)(1)(ii).

70. OAG finds that Respondents violated provisions of the 2011 AOD and the 2014 AOD.

71. Respondents neither admit nor deny OAG's Findings, Paragraphs 10 through 54, 69, and 70 above.

72. OAG finds the relief and agreements contained in this Assurance appropriate and in the public interest. THEREFORE, OAG is willing to accept this Assurance pursuant to Executive Law § 63(15), in lieu of commencing a statutory proceeding for violations of Executive Law § 63(12) based on the conduct described above during the period of January 1, 2020 through present.

IT IS HEREBY UNDERSTOOD AND AGREED, by and between the Parties:

RELIEF

Entities Bound By Assurance

73. This Assurance binds Emblem Health, Inc., EHPI, HIP, and EHIC, as well as their principals, officers, successors, and assigns.

Compliance with the Law

74. Respondents shall not engage, or attempt to engage, in conduct in violation of any applicable laws and regulations, including but not limited to New York Executive Law § 63(12); Insurance Law §§ 3217-a(a)(17), 4324(a)(17), 3241(a)(1), 3216(i)(31) & (35), 3221(l)(5) & (7), 4303(g) & (l), and 4226; Public Health Law §§ 4408(1)(r) and 4405(10); General Business Law §§ 349(a) and 350; 10 N.Y.C.R.R. 98-1.16(i); 42 U.S.C. § 300gg-115(a) and 300gg-26; and 45 C.F.R. §§ 146.136(c) and 156.230(a)(1)(ii), and expressly agree and acknowledge that any such conduct is a violation of the Assurance, and that OAG thereafter may commence the civil action

or proceeding contemplated in Paragraph 72, in addition to any other appropriate investigation, action, or proceeding.

PROGRAMMATIC RELIEF

75. Respondents will begin to implement the relief described in Paragraphs 78 through 104 below immediately upon the full execution of this Assurance.

76. For avoidance of any doubt, the relief described in Paragraphs 78 through 104 below apply to all commercial health plans, New York City employee health plans, Essential Plan products, Qualified Health Plans, Medicaid managed care plans, and Child Health Plus plans administered by Respondents, which collectively had a membership as of 1.5 million as of July 1, 2025. The relief described in Paragraphs 78 through 103 below does not apply to Medicare plans regulated by the Centers for Medicare & Medicaid Services ("CMS"), or to three self-funded ERISA medical benefit plans administered by Respondents (National Grid ASO, National Grid/KeySpan ASO, and Local 389, which collectively had 2,289 Members as of July 1, 2025).

77. The requirements set forth in Paragraphs 78 through 104 below apply to Online Provider Directories maintained on Respondents' own websites as well as Online Provider Directories maintained on websites operated by third parties that administer provider networks on behalf of Respondents.

78. Respondents shall maintain an Online Participating Provider Directory that includes an accurate listing for each Participating Provider ("Participating Provider Information") that shall include:

a. name, address, telephone number, licensure, and digital contact information;

b. whether the provider or facility is accepting new patients;

c. for mental health and substance use disorder providers, any affiliations with participating facilities certified or authorized by OMH or OASAS;

d. any restrictions regarding the availability of the individual provider or facility's services, including but not limited to any limits on the ages of patients that the provider treats or the type of specific behavioral health conditions that the provider treats;

e. languages other than English spoken by the Participating Provider; and

f. for physicians, board certification and any affiliations with participating hospitals.

The above-noted information shall also be published at least annually in a Print Directory made available to current and prospective Members, which shall contain a clear and conspicuous disclaimer that the information contained therein was accurate as of the date of publication and that Members should consult the Online Participating Provider Directory to obtain the most current provider directory information.

79. Respondents shall, on all Online Participating Provider Directories maintained on Respondents' own websites as well as Online Provider Directories maintained on websites operated by third parties that administer networks on behalf of Respondents, include a clear and conspicuous link next to each Participating Provider listing through which Members, Participating Providers, and members of the public can report inaccurate information contained in such directories. Respondents shall monitor reports of inaccurate directory information on a continuous basis.

80. Respondents shall, as of the Effective Date of this Assurance:

a. correct their Online Participating Provider Directory within two (2) business days after learning of, or receiving information regarding, the beginning or

termination of network agreements, and/or changes to the Participating Provider Information set forth in Paragraph 78 above.

b. within two (2) business days after Respondents learn that a provider is not accepting new patients, add a notation in the Online Participating Provider Directory that such provider is not accepting new patients, subject to the provisions of Paragraph 82, including but not limited to the claims analysis.

81. Respondents shall create and maintain the "Behavioral Health Participating Provider Directory Deletion/Addition Report," which shall include, for behavioral health providers who are removed from or added to their Online Participating Provider Directory, the following information: name, office address, date of removal or addition, reason for removal or addition, and if applicable, date on which their participation in Respondents' networks ended. As used in this Assurance, a "Behavioral Health Provider" is a New York-licensed or certified individual (psychiatrist, psychiatric nurse practitioner, master social worker, clinical social worker, psychologist, mental health counselor, creative arts therapist, marriage and family therapist, psychoanalyst, or credentialed alcoholism and substance abuse counselor) who treats behavioral health conditions, or a hospital, institution, facility, clinic, program, or agency licensed by OMH or OASAS. Within sixty (60) days after the Effective Date, Respondents shall submit to OAG the first Behavioral Health Participating Provider Directory Deletion/Addition Report, which shall include the results of the review process described in Paragraph 82(a)(ii)(3) below. Respondents shall submit to OAG the next Behavioral Health Participating Provider Directory Deletion/Addition Report six (6) months after the Effective Date, and subsequent reports at six-month intervals.

82. ***Verification Process***. Within thirty (30) days after the Effective Date, Respondents

shall submit to OAG for approval a written policy and procedure containing the provisions set forth in this Paragraph, establishing an Online Participating Provider Directory verification process ("Verification Process"). Respondents shall implement Paragraph 82(a)(ii)(3) within thirty (30) days after the Effective Date. Respondents shall implement the other provisions of the Verification Process within thirty (30) days after OAG approval. The Verification Process shall include the following:

a. Every ninety (90) days (a "Verification Cycle"), Respondents shall:

i. Outreach each credentialed behavioral health Participating Provider by electronic means, fax, or through U.S. mail (for those that opt out of electronic communications) to request they verify the accuracy of information included in their directory listing. Electronic means shall include, but not be limited to, a pop-up message triggered upon login to provider websites maintained by Respondents, which is linked to a directory information accuracy verification form.

ii. Stratify Participating Providers into three groups:

1. Providers who remain in the directory. These include providers who verified the accuracy of their directory information ***and*** do not fall within subsections (2) and (3) below.

2. Providers who remain in the directory but require further investigation. Regardless of whether a Participating Provider attests to the accuracy of their directory information, Respondents shall investigate the accuracy of the Participating Provider Information, including at least two follow-up contacts with providers—the second of which shall be via telephone—to

confirm their continued participation in Respondents' provider network, in the following situations:

a. Providers who have not submitted a claim within the last ninety (90) days. If Respondents do not timely confirm such providers' continued participation in Respondents' provider network, Respondents shall remove such providers from the Online Participating Provider Directory.

b. Providers with deactivated, invalid, missing or HHS OIG Exclusion-listed NPIs.

c. Providers listed as practicing at five or more unaffiliated locations.

d. Unlikely specialty combinations. For example, Participating Providers who practice at hospitals but are listed as treating outpatients, including providers under whose NPIs no outpatient claims have been submitted. If a Participating Provider practices at a hospital but does not treat outpatients, their Participating Provider Directory listing shall so indicate in a clear and conspicuous manner.

3. Providers who must be removed from the directory. Within thirty (30) days after the Effective Date, Respondents shall complete a review of their most recent provider verification information and, within fifteen (15) days after such review, remove Participating Providers: (i) who did not respond to Respondents' most recent verification request; and/or (ii) for whom Respondents have information, including but not limited to a response to a verification request or other communication to Respondents,

that they are no longer providing services or no longer participating with Respondents, or not accepting new patients. Thereafter, Respondents shall remove Participating Providers who do not verify their directory information within fifteen (15) days after a verification cycle, or within two (2) business days from when Respondents receive information, including but not limited to a response to a verification request or other communication to Respondents, that they are no longer providing services, or no longer participating with Respondents, regardless of a Verification Cycle. If a Provider does not verify their directory information within fifteen (15) days after a Verification Cycle, but in the past ninety (90) days has submitted to Respondents claims, request for authorization, and/or medical records, such Provider may remain in the directory but with a notation that they are not accepting new patients, and Respondents shall perform diligence to ensure the directory information for the provider is accurate and take all reasonable steps to secure a verification as soon as possible. If Respondents cannot verify such Providers' directory information, they shall remove such providers from its directory.

iii. Conduct rolling outreach such that each Participating Provider verifies the accuracy of their information every ninety (90) days. In other words, the provider's verification resets the 90-day cycle.

iv. Maintain documentation of all efforts undertaken in the Verification Process for each Participating Provider listed in their Online Participating Provider Directory, which shall accurately reflect the dates on which each provider's

Participating Provider status and Participating Provider Information were verified. If Respondents use telephone communications to verify Participating Provider status and Participating Provider Information as part of their Verification Process, they shall record any and all telephone calls.

v. Conduct educational outreach to professional associations to emphasize the importance of provider cooperation in Respondents' verification process.

83. ***Response Protocol***. Within thirty (30) days after the Effective Date, Respondents shall submit to OAG for approval a written policy and procedure containing the provisions set forth in this Paragraph, establishing a protocol for processing requests for information, complaints, grievances, and appeals from Members and others acting on their behalf (including family members and providers) relating to access to Participating Providers ("Response Protocol"). Respondents shall implement the Response Protocol within thirty (30) days after OAG approval. The Response Protocol shall include the following:

a. For Members who seek assistance finding or making an appointment with a Participating Provider and/or request information regarding whether a provider is in-network, Respondents shall reply to the Member to indicate whether the provider is a Participating Provider as soon as practicable and in no case later than one (1) business day after such communication is received. Respondents shall communicate with the Member in the manner (e.g., electronic, print, telephonic) as requested by the member, or if no such request, via the same means as the member used in the initial contact. If telephonic means are used and Respondents are unable to reach the Member by telephone, Respondents shall use a secondary means to reach the Member. Respondents shall retain such communication in

such Member's file for at least two (2) years following such response.

b. The Response Protocol shall include, and Respondents shall comply with, the following provisions:

i. Provide notice to Members in all complaint, grievance, and appeal acknowledgment and determination letters, adverse determination letters, explanations of benefits, and similar types of communications, regarding their rights under the 2025 New York network adequacy and access regulations, 11 NYCRR § 38.0, 10 NYCRR § 98.0, including their rights to file complaints related to inability to access services with a behavioral health provider ("Access Complaints") and receive out-of-network exceptions. For purposes of this Assurance, in addition to statutory or regulatory meanings, a "Complaint" shall include any communication in which a Member expresses any form of dissatisfaction ("Member Dissatisfaction"), including but not limited to difficulty locating a behavioral health provider, concerns about behavioral health providers, and/or frustration with any Emblem or Carelon process. "Member Dissatisfaction" includes but is not limited to any expression of frustration, anger, or disappointment, in tone or in words to the effect of "unhappy," "discuss with your supervisor," "someone else review," "have been waiting," "keep calling," "disappointed," "violate," "fed up," "too long," "confusing," "awful," "suffering," and "sensitive." For avoidance of doubt, to lodge a Complaint a member need not use the actual word "Complaint" or other specific words or phrases. If an Emblem or Carelon representative is unsure whether a Member wishes to lodge a Complaint, such

representative must treat the Member's communication as a Complaint.

ii. Consider any Access Complaint related to access to behavioral health services to be presumptively valid.

iii. Waive the three-day waiting period under 11 NYCRR § 38.0 and 10 NYCRR § 98.0 for Access Complaints in urgent cases. In this AOD, an "urgent case" is defined as an acute condition or a condition that may become an emergency if not treated.

iv. Before providing referrals or names of providers to Members, Respondents must contact such providers—via telephone or other means that may be approved by the OAG—and confirm in real time that they accept new patients and can treat the Member.

v. Respondents shall not state or suggest to Members that responsibility for accurate directories rests with providers.

vi. If a Member lodges a Complaint, grievance, or appeal regarding surprise bills, Respondents must inform the Member about the requirements under New York law (11 NYCRR § 52.77) and federal law (42 U.S.C. § 300gg-115(b)) that members be held harmless (responsible only for in- network cost-sharing) when a plan provides inaccurate network status information.

vii. If a Member lodges a Complaint, grievance, or appeal stating they called a provider after receiving a provider's information from Respondents and the information given about the provider's in-network status or ability to see new patients was inaccurate, Respondents must hold the member harmless (responsible only for in-network cost-sharing) unless Respondents can prove

with documentary evidence that it did not provide inaccurate information.

viii. If a Member lodges a Complaint, grievance, or appeal about a vendor or telehealth entity that contracts with Respondents (e.g., Valera, TalkSpace, etc.), Respondents must immediately escalate and resolve the Complaint, grievance, or appeal within three (3) business days, except in the case of expedited appeals under New York Insurance Law § 4904, in which case the appeal must be determined within two (2) business days, or twenty-four (24) hours for inpatient substance use disorder treatment.

ix. Respondents shall coordinate with any behavioral health vendor to resolve any Complaint, grievance, or appeal that such vendor believes does not concern behavioral health.

x. Respondents must consider any Complaint, grievance, or appeal relating to access to care under urgent time frames if the Complaint, grievance, or appeal indicates it could be urgent.

xi. Respondents must follow up with a Member who lodges a Complaint, grievance, or appeal about provider availability, to confirm the Member has made an appointment, by sending to the Member at least one communication by email or other means of contact requested by the Member, and making at least one phone call to the Member.

xii. Respondents must comply with the New York Continuity of Care law, N.Y. Ins. L. §§ 3217-d(c), 4306-c(c), 4804(e) & (f), and N.Y. Pub. Health L. § 4403(6)(e) & (f)), with respect to Members who lodge a Complaint, grievance, or appeal about their provider leaving Respondents' network.

84. ***Incorrect Directory Information Protocol.*** Within thirty (30) days after the Effective Date, Respondents shall submit to OAG for approval an Incorrect Directory Information Protocol containing the provisions set forth in this Paragraph. Respondents shall implement the Incorrect Directory Information Protocol within thirty (30) days after OAG approval. The Incorrect Directory Information Protocol shall include the following:

a. If Respondents provide inaccurate network status information to a Member, as defined below, Respondents must hold the Member harmless (responsible only for in-network cost-sharing).

b. Respondents shall be deemed to provide inaccurate network status information if Respondents:

i. indicate in their Online Participating Provider Directory that a non-participating provider is participating in Respondents' networks;

ii. indicate, through their Response Protocol, that a non-participating provider is participating in Respondents' networks;

iii. indicate incorrectly that a provider is accepting new patients;

iv. fail to provide information regarding a specific provider's participating status within one (1) business day of a request from a member; and/or

v. indicate in a print provider directory that a provider is a Participating Provider, but the provider was not a Participating Provider as of the date of publication.

c. The Incorrect Directory Information Protocol shall include, and Respondents shall comply with, the following provisions:

i. If a Member lodges a Complaint, grievance, or appeal stating they contacted

providers (including those given by Respondents), but such providers were not available or did not answer or respond, Respondents must deem such Complaint, grievance, or appeal substantiated unless Respondents timely prove otherwise, and hold the Member harmless, as defined above.

ii. If a Member lodges a Complaint, grievance, or appeal stating they called a provider Respondents provided but does not supply the name(s) of such provider(s), Respondents must search their files for all communications with such Member and cannot shift the burden to such Member to supply Respondents with information they already have.

iii. Respondents must remove providers they cannot reach from their Provider Directories, and from databases used to supply information to Members.

iv. Respondents cannot tell Members that Respondents lack jurisdiction over out-of-network providers.

85. ***Appointment Waiting Times.*** Respondents shall ensure that Members are able to obtain appointments with behavioral health providers within the following time frames ("Access Time Frames"):

a. For commercial members:

i. Emergency care: Member must be seen immediately.

ii. Urgent care: Member must be seen within twenty-four (24) hours.

iii. Initial appointment with an outpatient facility or clinic, or a health care professional not employed or contracted with an outpatient facility or clinic: Ten (10) business days.

iv. Appointment following a discharge from a hospital or an emergency room

visit: Seven (7) calendar days.

b. For Medicaid Members:

i. Emergency care: immediately upon presentation.

ii. Inpatient services: immediately upon presentation.

iii. Urgently needed services: twenty-four (24) hours.

iv. Non-urgent care: Seven (7) calendar days.

86. ***In-Network Exceptions.*** Within thirty (30) days of the Effective Date, Respondents shall submit for OAG approval a written policy and procedure that establishes a protocol for Members and others acting on their behalf, including but not limited to family members and providers, to request in-network exceptions when Members cannot obtain an appointment with an appropriate provider within Access Time Frames set forth above in Paragraph 85 (the "In- Network Exception Protocol"). Pursuant to such in-network exceptions, Members shall be held harmless (responsible only for in-network cost-sharing). The In-Network Exception Protocol shall include the following:

a. For Members who say they were unable to secure a timely appointment with a Participating Provider, Respondents shall have three (3) business days—except for emergent and urgent cases—from receipt of the Member communication to locate a Participating Provider that can treat the Member's behavioral health condition and is able to meet the appointment wait times set forth in Paragraph 85. If no appropriate Participating Provider is identified, Respondents shall allow the Member to see a non- participating provider and hold the Member harmless (responsible only for in- network cost-sharing), regardless of whether Respondents are able to enter into a single-case agreement with a provider.

b. Respondents shall use FAIRHealth out-of-network rates as the benchmark for negotiation of rates under single-case agreements.

87. ***Audits***. Respondents shall:

a. At least once per quarter, conduct behavioral health Participating Provider secret shopper surveys using the methodology set forth in OAG's December 2023 report titled "Inaccurate and Inadequate," and make the results publicly available.

b. For any audit or survey of Participating Provider directory accuracy or provider access and availability, including but not limited to digital audits and secret shopper surveys, include in calculations of rates of directory accuracy and provider access and availability all attempted contacts, including those that: (i) do not result in offers of appointments that satisfy the appointment availability standards set forth in this Assurance; or (ii) result in no response or answer, a wrong number or email, a disconnected number, or an unreturned call or voicemail.

88. ***Complaint Monitoring System***. Within thirty (30) days of the Effective Date, Respondents shall establish a Participating Provider Directory/Network Access Complaint Monitoring System ("Complaint Monitoring System"). Respondents shall:

a. log and track by date all Complaints, grievances, or appeals relating to the subject matter of this Assurance, including but not limited to inaccurate Online Participating Provider Directory listings, network access issues, and requests for in-network exceptions made to or through Respondents' regulatory affairs group, executive/concierge Complaint process or the like, customer service lines, and Complaint, grievance, and appeal processes.

b. document how each Complaint, grievance, and appeal was handled and resolved.

c. provide to OAG every six (6) months following the Effective Date of this Assurance a report listing the information contained in (a) and (b) ("Complaint Report").

89. ***Behavioral Health Participating Provider Recruitment and Retention Plan***. Within ninety (90) days of the Effective Date, to improve access to behavioral health services, Respondents shall create and submit to OAG a behavioral health provider recruitment and retention plan ("Behavioral Health Provider Recruitment and Retention Plan"), which shall include a detailed description of the mechanisms through which Respondents will work to expand their network of behavioral health providers. The Behavioral Health Provider Recruitment and Retention Plan shall include, at a minimum, specific proposals for: (a) outreach to New York-licensed behavioral health providers who are not currently Participating Providers, including psychiatrists, psychiatric nurse practitioners, master social workers, clinical social workers, psychologists, mental health counselors, creative arts therapists, marriage and family therapists, psychoanalysts, and credentialed alcoholism and substance abuse counselors; (b) periodically reviewing existing provider fee schedules and network needs for Behavioral Health Participating Providers; (c) reducing administrative burdens on providers; (d) estimating expected utilization of behavioral health services based on anticipated member enrollment and health care needs of the member population; (e) an analysis of the number and types of behavioral health care providers required to furnish covered behavioral health services, the number and types of providers actively providing behavioral health services within the health care plan's network, and the number and types of providers accepting new patients; (f) an analysis of the collection and monitoring of data on provider-to-enrollee ratios, travel time and

distance to participating providers, percentage of participating providers accepting new patients, and appointment wait times; and (g) investigating the role of telehealth in providing access to behavioral health services.

90. ***Training***. Respondents shall develop a written training protocol regarding the provisions in Paragraphs 78 through 89 above for all personnel involved in: administering Respondents' Online Provider Directory; ensuring directory accuracy; ensuring network adequacy; ensuring behavioral health parity; handling Member Complaints, grievances, and appeals relating to directory accuracy and/or network adequacy; and/or provider relations ("Relevant Personnel"), regardless of whether they are employed by Respondents or third parties, or are independent contractors. Respondents shall submit a written training protocol to OAG within thirty (30) days of OAG approval of the written policies and procedures described in Paragraphs 78-89.

a. Respondents shall train all Relevant Personnel based on the written materials. Key Relevant Personnel (as designated by Respondents and approved by OAG) shall be trained on the materials within three (3) months of OAG approval of such materials, and all other Relevant Personnel shall be trained within six (6) months of OAG approval of such materials. Thereafter, new Relevant Personnel will be trained within thirty (30) days of commencing their duties. Training will continue on an annual basis and must be provided to all Relevant Personnel no less than one time per year until three years after the Effective Date.

b. Respondents shall create and maintain records regarding all training conducted pursuant to this Paragraph, including records of attendance. Such records shall be reviewed by the Independent Monitor as part of its audits (as set forth below), and

provided to OAG no more than fourteen (14) days after a demand for such records is made.

91. Respondents shall make new and meaningful investments in implementing the following initiatives and, during the period in which the Independent Monitor functions (see Paragraphs 92 through 96 below), shall report annually to OAG a summary of the investments made:

a. Recruiting additional psychiatrists and psychiatric nurse practitioners who treat children and adolescents into Respondents' provider networks, through outreach efforts to: hospitals; clinics; professional associations; medical fellowship, residency and internship programs; medical schools; universities and colleges; behavioral health advocacy organizations; and other community resources.

b. Providing assistance to members in navigating Respondents' Online Provider Directories and locating behavioral health providers who can timely treat them in a convenient setting. This shall include hiring additional staff for customer service, and complaints, grievances and appeals.

c. Providing assistance to providers in navigating Respondents' directory information verification process. This shall include hiring additional staff for provider relations.

d. Conducting outreach to members regarding mental health services spanning the continuum of care that is available in their communities and covered by Respondents.

MONITORING AND OVERSIGHT BY INDEPENDENT MONITOR

92. Within thirty (30) days of the Effective Date, Respondents will designate a person or entity, subject to reasonable approval by OAG, with experience in directory accuracy and network adequacy processes, provider networks, behavioral health parity, and health insurance

claims processes, to serve as an independent monitor ("Independent Monitor"), who will submit to OAG bi-annual reports detailing Respondents' compliance with the requirements set forth in this Assurance, Paragraphs 78 through 90 (each, a "Compliance Report"). The first such Compliance Report shall be submitted to OAG nine (9) months after the Effective Date (the "First Compliance Report"). Subsequently, Respondents shall submit Compliance Reports every six (6) months, continuing until three (3) years after the First Compliance Report, subject to the provisions of Paragraph 95 below. In any case where the circumstances warrant, OAG may require an interim Compliance Report upon thirty (30) days' notice.

93. Within thirty (30) days after the OAG approves the Independent Monitor, Respondents shall make all necessary information available to the Independent Monitor, including but not limited to the Online Participating Provider Directory, network adequacy information, provider network information, and health claims data systems.

94. The Compliance Reports shall: (a) assess Respondents' compliance with the programmatic relief set forth above in Paragraphs 78 through 90; (b) describe the Independent Monitor's performance of the analyses set forth below in Paragraphs 97 through 103; and (c) report on administration of the restitution process set forth below in Paragraph 104. Each Compliance Report shall include: detailed results of the Independent Monitor's reviews, including relevant statistics; the Complaint Report (described above in Paragraph 88); the Behavioral Health Participating Provider Directory Deletion/Addition Report (described above in Paragraph 81); and a description and schedule of any corrective measures taken by Respondents or planned to be taken by Respondents.

95. If, after the Independent Monitor has submitted at least (4) four Compliance Reports to OAG, Respondents demonstrate substantial compliance with the terms of this

Assurance, and OAG agrees that Respondents are substantially compliant with the terms of this Assurance, the Independent Monitor shall cease to function. For avoidance of doubt, OAG retains its right to begin a new investigation.

96. If, after Respondents have submitted four compliance reports, OAG determines that Respondents are not substantially compliant with the terms of this Assurance, the Independent Monitor will continue to function and OAG shall produce a report setting forth Respondents' non-compliance with the terms of this Assurance and proposed steps for Respondents to come into compliance. Following such OAG report, the Independent Monitor, in consultation with OAG, shall develop a plan of corrective action for Respondents to achieve compliance with the terms of this Assurance. Thereafter, the Independent Monitor's role shall terminate upon the conclusion of a six-month reporting cycle that shall occur after OAG deems that Respondents are in substantial compliance with the terms of this Assurance. Respondents can exercise an option to replace the Independent Monitor if necessary, with OAG's consent, not to be unreasonably withheld.

97. ***Verification process review.*** The Independent Monitor shall:

a. take a statistically valid random sampling of Participating Providers who were subject to Respondents' Verification Process (the "Verified Providers");

b. compare the Participating Provider Information of the Verified Providers that is contained in Respondents' Online Participating Provider Directory with current source documentation obtained through their Verification Processes and other quality control processes. The Independent Monitor may consult Respondents' documentation, including claims data, applicable scripts, email notices, other correspondences and telephonic recordings, as well as independent data sources

used in the Verification Process described in Paragraph 82;

c. determine the percentage of those Verified Providers whose Participating Provider Information is accurately listed in Respondents' Online Participating Provider Directory (the "Accuracy Percentage"); and

d. if Respondents' Accuracy Percentage falls below the requirements set forth under federal and New York laws and regulations, as indicated by OAG, the Independent Monitor shall develop and present to OAG an appropriate remedial action plan, including additional protocols, monitoring and/or retraining.

98. ***Access review***. The Independent Monitor shall:

a. survey two statistically significant samples of Participating Providers (the "Access Sample") to determine their next available appointment. There shall be one sample for Participating Providers in Respondents' networks for commercial plans, and a second sample for Participating Providers in Respondent's networks for Medicaid, Essential Plan, and Child Health Plus plans;

b. determine the percentage of the Access Sample who have an available appointment within the Access Time Frames set forth in Paragraph 85 above (the "Access Percentage");

c. if Respondents' Access Percentage falls below the regulatory requirements set forth under federal and New York laws and regulations, as indicated by OAG, develop and present to Respondents and OAG an appropriate remedial action plan, including additional monitoring, recruiting, and/or retraining; and

d. assess whether Respondents have approved in-network exceptions for all Members who were unable to access an appropriate Participating Provider within the wait

times set forth in Paragraph 85, in accordance with Paragraph 86(a).

99. ***Out-of-network utilization review***. The Independent Monitor shall analyze Respondents' claims data to calculate:

a. by applicable rate code and provider type, the percentage of Members submitting claims for outpatient behavioral health treatment with out-of-network providers vs. in- network providers;

b. by applicable rate code and provider type, the percentage of Members submitting claims for outpatient medical/surgical treatment with out-of-network providers vs. in- network providers; and

c. the differences, if any, between (a) and (b).

100. ***Provider reimbursement review***. The Independent Monitor shall analyze a statistically valid random sampling of Respondents' claims data to calculate:

a. by applicable rate code and provider type, reimbursement rates for behavioral health Participating Providers;

b. by applicable rate code and provider type, reimbursement rates for medical/surgical participating providers; and

c. the differences, if any, between (a) and (b).

101. ***Network breadth review***. The Independent Monitor shall calculate:

a. the percentage of all behavioral health providers in Respondents' service area who are Participating Providers;

b. the percentage of all medical/surgical providers in Respondents' service area who are Participating Providers; and

c. The differences, if any, between (a) and (b).

102. ***Cultural competence review***. The Independent Monitor shall measure:

a. The percentage of Participating Providers who can communicate with patients in languages other than English, based on a provider attestation; and

b. The percentage of Participating Providers who have received cultural competence training, based on a provider attestation.

103. ***Consumer complaint review***. The Independent Monitor shall analyze Respondents' Complaint Reports and available related data to:

a. determine patterns of Complaints, grievances, and appeals regarding directory inaccuracy and network inadequacy;

b. determine opportunities for improvement, if any, in Respondents' responses to Complaints, grievances, and appeals; and

c. evaluate the sufficiency of Respondents' Complaint, grievance, and appeal mechanisms.

RESTITUTION

104. Respondents shall implement a restitution process, with eligibility and payment determinations to be adjudicated by the Independent Monitor, as follows:

a. For the period beginning January 1, 2020 through the Effective Date (the "Restitution Period"), Respondents shall provide restitution to all Members who fall into one or more of the following categories:

i. Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for behavioral health services rendered by non-participating providers who were incorrectly listed as participating providers in Respondents' Online Participating Provider Directory at the time

they received services ("Listed Non-Par Providers"). Listed Non-Par Providers shall include, but not be limited to, those providers who had terminated or disputed their participation status, or had not verified their participation status, but continued to be listed as participating providers. Such claims shall be referred to as "Directory Claims."

ii. Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for behavioral health services rendered by non-participating providers after being unable to secure an appointment with an appropriate in-network behavioral health provider. Such claims shall be referred to as "Network Claims."

iii. Respondents shall provide notice on their member website regarding Members' ability to submit Directory Claims and Network Claims.

b. Directory Claims.

i. Respondents shall make available to the Independent Monitor records sufficient to enable it to identify and review Directory Claims received during the Restitution Period.

ii. The Independent Monitor shall identify all Directory Claims and within sixty (60) days from the date that all Directory Claims are identified, Respondents shall issue restitution to each Member with a Directory Claim for amounts paid in excess of any applicable in-network co-payment, coinsurance, or deductible plus interest in the amount of 12 percent from the date of payment until the date restitution is issued, unless the Member has been reimbursed for

such Claim by another source. The Independent Monitor is permitted to request additional time to identify specific Directory Claims if needed.

iii. Members shall be entitled to submit additional Directory Claims to the Independent Monitor for services rendered during the Restitution Period by the Listed Non-Par Providers, which the Independent Monitor shall review to determine if such claims are valid Directory Claims.

c. Network Claims.

i. Within thirty (30) days of the Effective Date, Respondents shall submit to OAG for approval a form of notice ("Notice") that Respondents shall mail to all current and former Members, stating that Members may be eligible to submit Directory Claims and Network Claims. The Notice shall include:

1. a statement that all Members are entitled to submit restitution claims for services rendered by non-participating providers during the Restitution Period, after being unable to secure an appointment with an appropriate in-network behavioral health provider.

2. the procedures and timeframes for submitting a claim for restitution. Members will have one-hundred (100) days to submit claims from the date Respondents mail the Notices, except for Members who receive restitution for Directory Claims, who will have a one-time sixty (60) day period to submit additional Directory Claims after Respondents

mail the restitution payments.

3. A statement that Members may also submit Directory Claims for services rendered during the Restitution Period by the Listed Non-Par Providers.

ii. The Independent Monitor shall send the Notice to all Members within forty-five (45) days of OAG's approval of the Notice. Respondents shall also post the Notice in clear and conspicuous locations on their public and Member websites.

iii. The Independent Monitor shall evaluate each Network Claim to determine if the Member received services by a non-participating provider after being unable to secure an appointment with an appropriate in-network behavioral health provider (a "Valid Network Claim").

iv. Within thirty (30) days of the date of the Independent Monitor's determination of a Valid Network Claim, Respondents shall issue restitution to the Member for amounts paid in excess of any applicable in-network co- payment, coinsurance, or deductible plus interest in the amount of 12 percent from the date of payment until the date restitution is issued.

d. Within three (3) months of completion of restitution payments, the Independent Monitor shall submit to OAG a report documenting all Members who submitted claims for restitution, those to whom restitution was paid, those whose claims were denied, the provider's name and office address,

dates services rendered, restitution amount and date paid, and reason for denial, if applicable.

GENERAL PROVISIONS

105. Acceptance of this Assurance by OAG is not an approval or endorsement by OAG of any of Respondents' policies, practices, or procedures, and Respondents shall make no representation to the contrary.

106. Compliance with Other Obligations. In the event that Respondents reasonably believe that the performance of their obligations under any provision of this Assurance would conflict with any federal or state law or regulation that may be enacted or adopted after the Effective Date of this Assurance such that compliance with both this Assurance and such provision of law or regulation is not possible, Respondents shall notify OAG promptly and the Parties shall meet and confer at their earliest convenience to attempt to resolve such alleged conflict.

107. Respondents expressly agree and acknowledge that a default in the performance of any obligation under this Assurance is a violation of the Assurance against the defaulting Respondents, and that OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 72, in addition to any other appropriate investigation, action, or proceeding, and that evidence that the Assurance has been violated shall constitute prima facie proof of the statutory violations described in Paragraph 68, pursuant to Executive Law § 63(15).

Ongoing Cooperation

108. Respondents agree to cooperate with all ongoing requests by OAG for information related to this investigation and to ensure compliance with this Assurance.

Penalties, Fees, Costs

109. Respondents shall pay to the State of New York $2.5 million in penalties, fees, and costs. Payment shall be made in full by wire transfer within thirty (30) business days of the Effective Date of this Assurance. OAG shall provide transfer information to Respondents.

110. The Parties agree that it would be difficult to value the damages caused by default in the performance of any obligation under this Paragraph, and therefore agree that Respondents shall pay to the State of New York a stipulated penalty of $10,000 for each and every such material default in the performance of any obligation under this Paragraph occurring after the Effective Date of the Assurance.

Subsequent Proceedings

111. Respondents expressly agree and acknowledge that OAG may initiate a subsequent investigation, civil action, or proceeding to enforce this Assurance, for violations of the Assurance, or if the Assurance is voided pursuant to Paragraph 117, and agree and acknowledge that in such event:

a. any statute of limitations or other time-related defenses are tolled from and after the Effective Date of this Assurance;

b. OAG may use statements, documents or other materials produced or provided by Respondents prior to or after the Effective Date of this Assurance;

c. any civil action or proceeding must be adjudicated by the courts of the State of New York, and that Respondents irrevocably and unconditionally waive any objection based upon personal jurisdiction, inconvenient forum, or venue; and

d. evidence of a violation of this Assurance shall constitute prima facie proof of a violation of the applicable law pursuant to Executive Law § 63(15).

112. If a court of competent jurisdiction determines that Respondents have violated the Assurance, Respondents shall pay to OAG the reasonable cost, if any, of obtaining such determination and of enforcing this Assurance, including without limitation legal fees, expenses, and court costs.

Effects of Assurance

113. All terms and conditions of this Assurance shall continue in full force and effect on any successor, assignee, or transferee of Respondents. Respondents shall include in any such successor, assignment or transfer agreement a provision that binds the successor, assignee or transferee to the terms of the Assurance. No party may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without the prior written consent of OAG, which shall not be unreasonably withheld.

114. Nothing contained herein shall be construed as to deprive any person of any private right under the law.

115. Any failure by OAG to insist upon the strict performance by Respondents of any of the provisions of this Assurance shall not be deemed a waiver of any of the provisions hereof, and OAG, notwithstanding that failure, shall have the right thereafter to insist upon the strict performance of any and all of the provisions of this Assurance to be performed by Respondents.

Communications

116. All notices, reports, requests, and other communications pursuant to this Assurance must reference Assurance No. 24-009, and shall be in writing and shall, unless expressly provided otherwise herein, be given by hand delivery; express courier; or electronic mail at an address designated in writing by the recipient, followed by postage prepaid mail, and shall be addressed as follows:

If to Respondents, to: Michael Palmateer, or in his absence, to the person holding the title of Chief Legal Officer.
If to OAG, to: Michael Reisman, or in his absence, to the person holding the title of Bureau Chief, Health Care Bureau.

Any changes in the person to whom communications should be specifically directed shall be made in writing in advance of the change.

Representations and Warranties

117. OAG has agreed to the terms of this Assurance based on, among other things, the representations made to OAG by Respondents and their counsel and OAG's own factual investigation as set forth in Findings, Paragraphs 10 through 54 above. Respondents represent and warrant that neither they nor their counsel have made any material representations to OAG that are inaccurate or misleading. If any material representations by Respondents or their counsel are later found to be inaccurate or misleading, this Assurance is voidable by OAG in its sole discretion.

118. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by Respondents in agreeing to this Assurance.

119. Respondents represent and warrant, through the signatures below, that the terms and conditions of this Assurance are duly approved. Respondents further represent and warrant that Emblem Health, Inc., EHPI, HIP, and EHIC, by Michael Palmateer, as the signatory to this Assurance, is a duly authorized officer acting at the direction of the Boards of Directors of Emblem Health, Inc., EHPI, HIP, and EHIC.

General Principles

120. Unless a term limit for compliance is otherwise specified within this Assurance, Respondents' obligations under this Assurance are enduring.

121. Nothing in this Assurance shall relieve Respondents of other obligations imposed by any applicable state or federal law or regulation or other applicable law.

122. Respondents shall not in any manner discriminate or retaliate against any health care providers who cooperated or are perceived to have cooperated with the investigation of this matter or any future investigation related to enforcing this agreement.

123. Respondents agree not to take any action or to make or permit to be made any public statement denying, directly or indirectly, any finding in the Assurance or creating the impression that the Assurance is without legal or factual basis. This paragraph shall not (a) preclude Respondents from acknowledging that, by entering the Assurance, it did not admit to the OAG's Findings and entered the Assurance to avoid the time and expense of litigation, (b) affect Respondents' testimonial obligations, or (c) affect Respondents' right to take legal or factual positions in response to, or defense of, any inquiry, audit, litigation or other proceedings, including, without limitation, any inquiry or action brought by an individual, entity, or governmental authority other than the OAG.

124. Nothing contained herein shall be construed to limit the remedies available to OAG in the event that Respondents violate the Assurance after its Effective Date.

125. This Assurance may not be amended except by an instrument in writing signed on behalf of the Parties to this Assurance.

126. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held by a court of competent jurisdiction to be invalid, illegal, or unenforceable in any respect, in the sole discretion of OAG, such invalidity, illegality, or unenforceability shall not affect any other provision of this Assurance.

127. Respondents acknowledge that they have entered this Assurance freely and

voluntarily and upon due deliberation with the advice of counsel.

128. This Assurance shall be governed by the laws of the State of New York without regard to any conflict of laws principles. The Assurance and all its terms shall be construed as if mutually drafted with no presumption of any type against any party that may be found to have been the drafter.

129. This Assurance may be executed in multiple counterparts by the parties hereto. All counterparts so executed shall constitute one agreement binding upon all parties, notwithstanding that all parties are not signatories to the original or the same counterpart. Each counterpart shall be deemed an original to this Assurance, all of which shall constitute one agreement to be valid as of the Effective Date of this Assurance. For purposes of this Assurance, copies of signatures shall be treated the same as originals. Documents executed, scanned and transmitted electronically and electronic signatures shall be deemed original signatures for purposes of this Assurance and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures.

130. The Effective Date of this Assurance shall be February 19, 2026.

LETITIA JAMES
Attorney General of the State of New York
28 Liberty Street
New York, NY 10005

By: *Michael D. Reisman*

Michael D. Reisman
Assistant Attorney General
Health Care Bureau

Emblem Health, Inc., EmblemHealth Plan, Inc. f/k/a Group Health Incorporated, Health Insurance Plan of Greater New York d/b/a HIP Health Maintenance Organization, and EmblemHealth Insurance Company f/k/a HIP Insurance Company of New York

By: *Michael Palmateer*

Michael Palmateer
Chief Executive Officer