UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JANE DOE, on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated Plaintiffs, v. ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS Defendant.	Case No. 24 Civ. 8012 (JPC)

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

Date: May 2, 2025

Steve Cohen
Anna Menkova
POLLOCK COHEN LLP
111 Broadway, Suite 1804
New York, NY 10006
Tel: (646) 517-0542
scohen@pollockcohen.com
anna@pollockcohen.com

Jacob Gardener
Samuel Rosh
WALDEN MACHT HARAN & WILLIAMS LLP
250 Vesey Street, 27th Floor
New York, NY 10281
Tel: (212) 335-2030
jgardener@wmhwlaw.com
srosh@wmhwlaw.com

Attorneys for Plaintiffs

TABLE OF CONTENTS

Pages

TABLE OF AUTHORITIES

Pages

Cases

Statutes

Regulations

Other Authorities

Plaintiffs Jane Doe, on behalf of Baby Doe, and Patricia Cavallaro-Kearins respectfully submit this memorandum of law in opposition to defendant Anthem HealthChoice Assurance, Inc.'s ("Anthem") motion to dismiss the Complaint ("Mot.").

PRELIMINARY STATEMENT

This case concerns Anthem's practice of providing grossly inaccurate information about its mental health provider network to the federal employees enrolled in its health insurance plan. In violation of its contractual, statutory, and common-law duty to maintain an accurate directory of available, in-network providers, Anthem has published a directory in which more than 80% of the doctors and therapists listed are not actually in-network, do not exist, are not accepting new patients, or cannot be reached using the listed contact information. By greatly exaggerating the adequacy of its provider network, Anthem attracts enrollees under false pretenses. This deception has caused serious harm to enrollees like Plaintiffs, who have been unable to find mental health providers, have had to forgo medically necessary care, and have incurred thousands of dollars in unexpected out-of-network costs. Plaintiffs therefore pursue contractual, statutory, and common-law claims on behalf of a putative class.

Anthem does not dispute in its motion to dismiss that Plaintiffs have adequately alleged these claims. Instead, Anthem argues that Plaintiffs' claims are preempted by federal law (expressly or by implication), that Plaintiffs have failed to exhaust administrative remedies, and that Plaintiffs are not intended third-party beneficiaries entitled to sue Anthem under the contract governing their health insurance plan. But Anthem makes remarkably little effort to conform its arguments to Supreme Court and Second Circuit precedent. That precedent makes clear that Plaintiffs' claims are not preempted. It makes clear that Anthem cannot rewrite the regulation governing administrative exhaustion, which does not apply to the claims Plaintiffs pursue here. And it makes clear that Plaintiffs are intended third-party beneficiaries who are entitled to hold

Anthem to its promise to maintain an accurate directory of in-network providers. The motion to dismiss should be denied.

BACKGROUND

Plaintiffs are federal employees (or the beneficiary of a federal employee) who enrolled in Anthem's BlueCross BlueShield insurance plan. Compl. ¶¶ 70, 85. Plaintiffs allege that Anthem has failed to maintain current and accurate records of in-network mental health providers, in violation of its contractual obligations. *Id.* ¶¶ 36–48, 117–68. In particular, Anthem agreed in its contract with the federal Office of Personnel Management ("OPM") to comply with various provisions of the No Surprises Act, including those requiring insurers to (i) maintain a directory of in-network providers and their contact information, (ii) update that directory at least every 90 days, and (iii) remove those providers who the insurer can no longer reach. *See* Pub. L. 116-260, § 116, 134 Stat. 1182, 2878–89 (2020); Compl. ¶¶ 117–21; Dkt. 26-2 at 54 (2022 OPM contract).[1] Anthem also represents to customers and prospective customers, including during open-enrollment season, that providers listed in its directory accept Anthem's insurance and are available to take new patients. Compl. ¶¶ 126–28, 150–64.

The reality is far different. An extensive survey of mental health providers in Anthem's directory revealed that the directory was grossly inaccurate and that virtually all surveyed providers (i) were not in-network, (ii) were not accepting new patients for outpatient mental health services, and/or (iii) had incorrect contact information. *Id.* ¶¶ 140–47. Anthem thus maintains a so-called "ghost network"—*i.e.*, a directory of providers that contains so many errors that it is functionally impossible to use it to find in-network providers. *Id.* ¶¶ 1–2, 51–69. The prevalence

[1] Plaintiffs have no objection to this Court's considering, as incorporated by reference, Anthem's contracts with OPM and the associated statements of benefits. *See* Mot. at 3 n.2, 4 n.4; Dkt. 26 (attaching those documents to Anthem's motion to dismiss).

of ghost networks was a key impetus for passage of the No Surprises Act. *Id.* ¶¶ 36–39.

Plaintiffs' experiences with Anthem's ghost network are representative. Plaintiff Patricia Cavallaro-Kearins has been diagnosed with ADHD and anxiety and sought treatment for those conditions. *Id.* ¶ 73. She attempted to use Anthem's directory to find an in-network psychiatrist and spent many hours calling providers listed in the directory, but could not find a single in-network provider. *Id.* ¶¶ 74, 79–81, 83. She also attempted to call Anthem directly, which was unable to help her find an in-network provider. *Id.* ¶ 75. Anthem's failure to maintain an accurate directory left Ms. Cavallaro-Kearins with no option other than to obtain care from an out-of-network provider, which was considerably more expensive than an in-network physician and which she could not afford for long. *Id.* ¶¶ 76, 80, 82–83.

Baby Doe's experience was, if anything, worse. Baby Doe, the child of federal employee Jane Doe, has been diagnosed with autism spectrum disorder. *Id.* ¶¶ 85, 88. Baby Doe requires regular occupational and speech therapy, along with mental health treatment. *Id.* ¶ 88. Her mother attempted to use Anthem's directory to find in-network providers but was unable to do so. *Id.* ¶¶ 90–91, 94. Jane Doe spent hours calling providers in the directory, but found that the directory contained inaccurate information about the listed providers. *Id.* ¶¶ 91, 94. Ultimately, Jane Doe could not find an in-network provider for Baby Doe and could not afford out-of-network care. *Id.* ¶ 93. Baby Doe has had to forgo care altogether. *Id.* ¶¶ 93, 96.

Plaintiffs now seek relief for Anthem's false and deceptive representations regarding its provider network. Plaintiffs pursue claims for breach of contract, deceptive business practices, false advertising, violation of N.Y. Insurance Law § 4226, fraudulent misrepresentation, and unjust enrichment, and seek damages and equitable relief on behalf of a putative class. *Id.* ¶¶ 216–84.

ARGUMENT

Anthem seeks dismissal on four grounds: express preemption, implied preemption, failure to exhaust administrative remedies, and dismissal of the contract claim on the theory that Plaintiffs are not intended third-party beneficiaries. Each of these arguments is meritless.[2]

I. Plaintiffs' Claims Are Not Preempted By FEHBA

Under Second Circuit precedent, Plaintiffs' claims are not preempted by the Federal Employees Health Benefits Act's ("FEHBA") preemption clause. The Second Circuit has held that laws of general application—*i.e.*, laws that are not specific to the regulation of health insurance—are not preempted by FEHBA. *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145–46 (2d Cir. 2005), *adhered to on petition for rehearing*, 402 F.3d 107 (2d Cir. 2005), *aff'd on other grounds*, 547 U.S. 677 (2006). That precisely describes the claims that Plaintiffs pursue here, which allege violations of generally applicable contract, tort, and consumer-protection law. Anthem's attempt to evade the Second Circuit's precedent is unavailing.

Under FEHBA's preemption clause, "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). "When a federal law contains an express preemption clause, [courts] focus on the plain wording of the clause, which necessarily

[2] Anthem has waived the argument (raised in its pre-motion conference letter) that sovereign immunity bars Plaintiffs' claims by failing to make the argument in its opening brief. *See Stoneline Grp., LLC v. Liberty Mut. Ins. Co.*, 2025 WL 934871, at *8 (S.D.N.Y. Mar. 27, 2025) ("it is well-established that arguments not made in an opening brief are waived" (internal quotation marks and ellipsis omitted)); *Dist. Att'y of N.Y. Cnty. v. Republic of the Phil.*, 307 F. Supp. 3d 171, 216–17 (S.D.N.Y. 2018) ("The Second Circuit has held that the failure to assert sovereign immunity in a responsive pleading is a waiver." (internal quotation marks omitted)). In any event, the argument fails for the reasons stated in Plaintiffs' pre-motion conference letter. Dkt. 18 at 3.

contains the best evidence of Congress' preemptive intent." *Chamber of Com. of U.S. v. Whiting*, 563 U.S. 582, 594 (2011) (internal quotation marks omitted); *contra* Mot. at 9–10 (advancing arguments based on FEHBA's supposed purpose and legislative history).

As the Supreme Court has explained, FEHBA "places two preconditions on federal preemption." *Coventry Health Care of Mo., Inc. v. Nevils*, 581 U.S. 87, 94 (2017); *see also Empire HealthChoice*, 396 F.3d at 145 (describing same "[t]wo independent conditions"). "First, preemption only occurs when the FEHBA contract terms at issue 'relate to the nature, provision, or extent of coverage or benefits.' Second, federal law may only preempt state or local laws if those laws 'relate[] to health insurance or plans.'" *Empire HealthChoice*, 396 F.3d at 145 (internal citation omitted and brackets in original); *accord Nevils*, 581 U.S. at 94–95. Plaintiffs' claims are not preempted because they do not arise under laws "relat[ing] to health insurance or plans" and thus do not satisfy the second preemption precondition. 5 U.S.C. § 8902(m)(1).

The Second Circuit made that conclusion clear in *Empire HealthChoice*. 396 F.3d 136. The Court there considered whether there was federal jurisdiction in a contract dispute between a federal employee, as the insured, and Empire, as the insurance carrier. Empire claimed federal jurisdiction was proper because, among other reasons, FEHBA preempted state contract law. *Id.* at 145. The Court, in an opinion by then-Judge Sotomayor, held that FEHBA did not preempt state contract law because contract law did not "relate to health insurance or plans." *Id.* As the Court explained, Empire's argument "completely ignores the existence of this second [preemption] condition, arguing erroneously that because the contract provisions at issue relate to benefits, they necessarily supersede 'all state law.' Without any showing that the dispute implicates a specific state law or state common-law principle 'relat[ing] to health insurance,' § 8902(m)(1) does not authorize federal preemption of state law in this case." *Id.* (second brackets in original).

The Second Circuit then rejected the argument that "the case satisfies the second condition for § 8902(m)(1) preemption on the ground that the phrase 'state or local law . . . which relates to health insurance or plans' encompasses laws of general application that make absolutely no reference to health insurance or plans but are used in a given case to 'construe or enforce' FEHBA plans." *Id.* at 146 (ellipsis in original). As the Court explained, that interpretation of FEHBA's preemption clause "renders the second limiting condition meaningless" because, under that interpretation, *any* state or local law that satisfies the first preemption requirement would be preempted. *Id.* The Second Circuit held that the only way to give the second preemption requirement "independent meaning" was to interpret it to apply only to state or local laws that "implicate[] a specific state law or state common-law principle 'relat[ing] to health insurance.'" *Id.* at 145–46 (internal citation omitted and second brackets in original). Thus, the Court held that FEHBA's preemption clause does not "encompass[] laws of general application" that do not *specifically* relate to health insurance or plans. *Id.* at 146.

The Second Circuit's interpretation of FEHBA's preemption clause compels the conclusion that Plaintiffs' claims—which arise under laws of general application—are not preempted. That is true even though the Supreme Court affirmed the Second Circuit's judgment in *Empire HealthChoice* on other grounds. The Supreme Court held that, whatever the proper construction of FEHBA's preemption clause, "that provision is not sufficiently broad to confer federal jurisdiction." 547 U.S. at 698. Rather, "[i]f Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear." *Id.* The Second Circuit has held that when, as in *Empire HealthChoice*, the Supreme Court affirms a decision on alternative grounds, the Second Circuit's earlier ruling "remains the law of this Circuit, notwithstanding the Supreme

Court's decision . . . affirming this Court's judgment on other grounds." *In re Arab Bank, PLC Alien Tort Statute Litig.*, 808 F.3d 144, 151 (2d Cir. 2015). Even when the Supreme Court's decision "seems to suggest that the Court was less than satisfied with our approach to jurisdiction," the Supreme Court "neither said as much nor purported to overrule [the Second Circuit's reasoning]. The two decisions adopted different bases for dismissal for lack of subject-matter jurisdiction. Whatever the tension between them, the decisions are not logically inconsistent." *Id.* at 153. Likewise here, the Second Circuit's interpretation of FEHBA's preemption clause was in no way displaced by the Supreme Court's decision *not* to adopt a particular interpretation of FEHBA in *Empire HealthChoice*.[3]

Anthem alternatively suggests that the Second Circuit's analysis in *Empire HealthChoice* was "dicta" because the case "related solely to whether federal question jurisdiction existed, not whether express preemption occurred," but that is wrong. Mot. at 11. The Second Circuit's interpretation of FEHBA's preemption clause was clearly not dicta, as that statutory construction formed the basis for the Second Circuit's conclusion that federal jurisdiction did not lie. *See Alsol v. Mukasey*, 548 F.3d 207, 218–19 (2d Cir. 2008) (explaining that a statement is dicta where it was "not necessary to our holding"). Nor is the Second Circuit's holding inapplicable here merely because that Court assessed whether there was subject-matter jurisdiction, while this Court must assess the merits of Anthem's preemption defense. The Second Circuit's holding depended on its interpretation of FEHBA's preemption clause, and it is "a judicial decision's reasoning—its *ratio*

[3] Plaintiffs therefore respectfully disagree with *Mahajan v. Blue Cross Blue Shield Ass'n*, 2017 WL 4250514, at *8 (S.D.N.Y. Sept. 22, 2017), which concluded that the Second Circuit's analysis in *Empire HealthChoice* was "dicta" principally because the Supreme Court affirmed on other grounds. *Mahajan* did not address the Second Circuit's holding in *Arab Bank* that the Supreme Court's affirmance on alternative grounds ordinarily does not displace the Second Circuit's earlier holding. 808 F.3d at 151, 153.

decidendi—that allows it to have life and effect in the disposition of future cases." *Ramos v. Louisiana*, 590 U.S. 83, 104 (2020) (plurality opinion); *see id.* at 104 n.54 ("The traditional answer to the question of what is a precedent is that subsequent cases falling within the *ratio decidendi*—or *rationale*—of the precedent case are controlled by that case." (internal quotation marks omitted and alteration adopted)). Thus, although the Second Circuit's decision came in the context of subject-matter jurisdiction, its construction of the statute was not limited to that context.

Finally, there is no basis for concluding that the Supreme Court's later decision in *Nevils* abrogated the Second Circuit's analysis in *Empire HealthChoice*. *Contra* Mot. at 12. In *Nevils*, the Supreme Court held that subrogation and reimbursement requirements in OPM's contract with insurance carriers satisfied the first preemption requirement, *i.e.*, they "relate to the nature, provision, or extent of coverage or benefits." 581 U.S. at 95. But the Court did *not* analyze whether state laws prohibiting subrogation and reimbursement "relate[] to health insurance or plans" because "[t]he parties agree[d]" that they did. *Id.* at 94. The Court therefore proceeded on that assumption and did not analyze the second preemption requirement, even as the Court described it as a distinct "precondition[]" to federal preemption. *Id.*; *see Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 749 F. Supp. 3d 456, 471–72 (S.D.N.Y. 2024) (explaining that in *Nevils*, "the Court did not have reason to discuss the second prong of FEHBA preemption" in light of the parties' agreement, and holding that unjust enrichment claim was not preempted under FEHBA by analogy to ERISA preemption). Because the Supreme Court did not address the second preemption requirement, the Second Circuit's analysis of that requirement remains binding. *See Chery v. Garland*, 16 F.4th 980, 987 (2d Cir. 2021) (holding that earlier Second Circuit precedent "remains good law" after Supreme Court decision because Supreme Court "did not question" the issue addressed in Second Circuit case); *DiLeo v. Comm'r*, 959 F.2d

16, 19 (2d Cir. 1992) (holding that even when the Supreme Court abrogates one part of Second Circuit precedent, that precedent "remains the law in this circuit" on an issue that "the Supreme Court did not address").

Plaintiffs therefore respectfully disagree with the *Mahajan* court, which concluded that laws of general applicability can be preempted by FEHBA. In *Mahajan*'s view, the Supreme Court in *Nevils* implicitly signaled disagreement with the Second Circuit's analysis in *Empire HealthChoice* because subrogation laws are laws of general application insofar as they apply to all forms of insurance, not merely health insurance. *Mahajan*, 2017 WL 4250514, at *8; *see* Mot. at 12. But that overreads the Supreme Court's decision, which did not assess the second preemption requirement in light of the parties' agreement that it was satisfied. As the Supreme Court has explained, it frequently "decide[s] particular legal issues while assuming without deciding the validity of antecedent propositions, and such assumptions—even on jurisdictional issues—are not binding in future cases that directly raise the questions." *Domino's Pizza, Inc. v. McDonald*, 546 U.S. 470, 478–79 (2006) (internal quotation marks omitted); *see Brecht v. Abrahamson*, 507 U.S. 619, 631 (1993) (explaining that prior cases are not binding where they "never squarely addressed the issue, and have at most assumed the applicability" of a particular legal standard). And even if this Court perceived any latent tension between *Nevils* and the Second Circuit's holding in *Empire HealthChoice*, the Second Circuit has instructed that district courts should not disregard its precedent on that basis. Rather, "a District Court must follow controlling precedent—even precedent the District Court believes may eventually be overturned—rather than preemptively declaring that our caselaw has been abrogated." *Packer v. Raging Cap. Mgmt., LLC*, 105 F.4th 46, 50 (2d Cir. 2024). A district court may not "decline[] to follow" Second Circuit precedent when it believes the Supreme Court has "cast doubt on that controlling precedent." *Id.* at 53–54

(internal quotation marks omitted). Rather, "[t]hat is the standard by which *this Court* reconsiders its own precedent. District Courts, by contrast, are obliged to follow our precedent, even if that precedent might be overturned in the near future." *Id.* at 54 (emphasis in original and internal quotation marks omitted).

In any event, even if this Court considered the matter afresh, the Second Circuit was clearly correct that only its reading gives "independent meaning" to the second condition for FEHBA preemption. *Empire HealthChoice*, 396 F.3d at 146. By way of reminder, FEHBA's preemption clause states: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). Anthem's argument that this statute preempts laws of general application would render superfluous the phrase "which relates to health insurance or plans." After all, if that phrase were stricken from the text, the statute would already preempt state or local laws that "relate to the nature, provision or extent of coverage or benefits" provided to federal employees under FEHBA contracts. *But see Springfield Hosp. v. Guzman*, 28 F.4th 403, 427 (2d Cir. 2022) (courts "are obliged to give effect, if possible, to every clause and word of a statute, and to render none superfluous" (internal quotation marks omitted)). Instead, to give each word independent effect, the phrase "which relates to health insurance or plans" is best understood to describe the type of state or local law being preempted—*i.e.*, the state law must specifically "relate[] to health insurance or plans." *See Galper v. JP Morgan Chase Bank, N.A.*, 802 F.3d 437, 445 (2d Cir. 2015) ("As with any preemption provision, we construe [the statute] fairly but narrowly, mindful in the appropriate case that each phrase within the provision limits the universe of state action pre-empted by the statute." (internal quotation marks omitted and alterations

adopted)); *id.* at 447 (narrowly construing the phrase "relating to" in preemption statute where, in context, a broader preemptive intent would have used different wording).[4]

In short, Plaintiffs' claims are not preempted by FEHBA because they do not satisfy the second preemption condition. Anthem acknowledges that most of Plaintiffs' claims (for breach of contract, deceptive business practices, false advertising, fraudulent misrepresentation, and unjust enrichment) arise under laws of general application, but wrongly suggests that the same conclusion does not obtain for Plaintiffs' claim under N.Y. Insurance Law § 4226 because that statute applies to insurers in "the business of life, or accident and health insurance[.]" Mot. at 11. That misses the point: although § 4226 mentions "health insurance," it is a law generally applicable to the provision of various forms of insurance. Indeed, Anthem makes a version of this same point when discussing the subrogation rule addressed in *Nevils*: as Anthem observes, subrogation "is not specific to health insurance" but rather applies to all forms of insurance, such that it is a state law of "general application." Mot. at 12. Likewise here, § 4226 is not a "specific state law . . . relating to health insurance," so it is not preempted. *Empire HealthChoice*, 396 F.3d at 145 (alteration adopted). None of Plaintiffs' claims is preempted by statute.

[4] *Mahajan* concluded that laws of general applicability are preempted by FEHBA and reasoned that its interpretation of the statute still gave the second preemption requirement independent meaning, because the phrase "'relates to health insurance or plans' limits the scope of preemption and prevents the provision from preempting *all* state laws which would be an absurd result." 2017 WL 4250514, at *8 (emphasis in original). But there is no risk of that "absurd result" because the first preemption requirement already limits the statute's preemptive scope to those contractual terms "relat[ing] to the nature, provision, or extent of coverage or benefits" in contracts involving federal employee health insurance benefits. Only Plaintiffs' interpretation—endorsed by the Second Circuit—gives the second preemption requirement independent meaning by further limiting the statute's preemptive sweep. *See Empire HealthChoice*, 396 F.3d at 146 & n.11 (rejecting argument similar to Anthem's because it fails to "demonstrate that the second condition imposes any limits not already imposed by the first condition").

II. Plaintiffs' Claims Are Not Preempted by Implication

Nor are Plaintiffs' claims preempted by implication, as those claims are entirely consistent with Anthem's obligation to the federal government. Anthem suggests that Plaintiffs' claims are impliedly preempted because they would undermine the uniform administration of FEHBA plans, interfere with OPM's authority over those plans, and stand as an obstacle to Congress's objectives. Mot. at 13–16. This argument flatly ignores Supreme Court and Second Circuit authority.

"[E]very preemption case starts with the presumption that Congress did not intend to displace state law." *N.Y. Pet Welfare Ass'n, Inc. v. City of N.Y.*, 850 F.3d 79, 86 (2d Cir. 2017). Conflict preemption applies "only if" Anthem "can clearly demonstrate that (a) compliance with both [state and federal law] is physically impossible, or (b) [state law] stands as an obstacle to the accomplishment and execution of the full congressional purposes and objectives stated in" FEHBA. *Madeira v. Affordable Hous. Found., Inc.*, 469 F.3d 219, 241 (2d Cir. 2006); *see English v. Gen. Elec.*, 496 U.S. 72, 79 (1990). Anthem does not argue that it is impossible to comply with both FEHBA and the state contract, consumer-protection, and tort laws invoked by Plaintiffs; rather, it relies solely on principles of obstacle preemption.[5]

Obstacle preemption "precludes state law that poses an actual conflict with the overriding federal purpose and objective," and "the conflict between state law and federal policy must be a sharp one." *In re MTBE Prods. Liab. Litig.*, 725 F.3d at 101 (internal quotation marks omitted). "The burden of establishing obstacle preemption, like that of impossibility preemption, is heavy: the mere fact of 'tension' between federal and state law is generally not enough to establish an

[5] Nor does Anthem argue that Plaintiffs' claims are preempted on the basis that Congress has "legislate[d] so comprehensively in one area as to 'occupy the field.'" *In re MTBE Prods. Liab. Litig.*, 725 F.3d 65, 97 (2d Cir. 2013) (describing field preemption as distinct from the implied preemption arguments advanced in Anthem's motion); *see* Mot. at 14–16 (relying on conflict preemption principles).

obstacle supporting preemption." *Id.* at 101–02 (internal quotation marks omitted). Rather, "federal law does not preempt state law under obstacle preemption analysis unless the repugnance or conflict is so direct and positive that the two acts cannot be reconciled or consistently stand together." *Id.* at 102 (internal quotation marks omitted).

That is not this case. As the Second Circuit has explained, there is no obstacle preemption when federal and state law "serve[] to reinforce the . . . purpose of the other." *Figueroa v. Foster*, 864 F.3d 222, 235 (2d Cir. 2017). There is no conflict between federal law and Plaintiffs' attempt to compel Anthem to comply with its contractual obligations and refrain from grossly misrepresenting the adequacy of its provider network. *See* Compl. ¶¶ 227–84. Anthem's contract mandates that it verify and update its provider directory, *id.* ¶ 230, and Plaintiffs seek to enforce that contract and prevent Anthem from misrepresenting its provider network, *id.* ¶¶ 234–84. "This mutual service [between federal and state law] is not a conflict such that" they "cannot be reconciled or consistently stand together." *Figueroa*, 864 F.3d at 235 (internal quotation marks omitted). "Instead, the two work in tandem to protect" federal employees. *Id.*

Contrary to its representation, Anthem identifies no statute that grants OPM "exclusive authority" to regulate FEHBA insurance carriers. Mot. at 14. Rather, FEHBA prescribes certain "minimum standards for health benefit plans" and authorizes OPM to enter into contracts, 5 U.S.C. § 8902(e), but nowhere suggests that state law is displaced other than in the express preemption clause discussed above. And although federal regulations do require insurance carriers to ensure that their marketing material is "truthful and not misleading" and authorize certain penalties OPM may impose for failure to comply, 48 C.F.R. § 1652.203–70, there is again no indication that those remedies are intended to be exclusive. *See Hillsborough Cnty. v. Automated Med. Lab'ys*, 471 U.S. 707, 717 (1985) ("We are even more reluctant to infer pre-emption from the

comprehensiveness of regulations than from the comprehensiveness of statutes.").

Indeed, the Supreme Court has held that state-law claims are not preempted merely because a federal agency has some authority to regulate the relevant business. *See Wyeth v. Levine*, 555 U.S. 555, 574–77 (2009) (holding that FDA's authority to regulate and approve drugs, and their labeling, does not preempt state tort claims under conflict-preemption theory). As the Court explained, "[i]f Congress thought state-law suits posed an obstacle to its objectives, it surely would have enacted an express pre-emption provision at some point during the" FDA's history. *Id.* at 574. "Its silence on the issue, coupled with its certain awareness of the prevalence of state tort litigation, is powerful evidence that Congress did not intend FDA oversight to be the exclusive means of ensuring drug safety and effectiveness." *Id.* Although Congress did enact an express preemption provision in FEHBA, the inapplicability of that provision here is likewise "powerful evidence" that Congress had no intent to preempt state-law claims falling outside the statute's ambit. *Id.*; *see also Altria Grp., Inc. v. Good*, 555 U.S. 70, 89 (2008) (state-law misrepresentation claim not preempted based on "[t]he FTC's failure to require petitioners to correct their allegedly misleading" statement). Tellingly, Anthem has no response to the Supreme Court and Second Circuit's blessing of state-law contract actions between insurance carriers and federal employees, which likewise shows that the federal government is not the exclusive overseer of the insurer-employee relationship. *Empire HealthChoice*, 547 U.S. at 692–93; 396 F.3d at 141–42.

Plaintiffs therefore respectfully disagree with *Mahajan*'s holding that state-law misrepresentation claims are impliedly preempted by FEHBA due to (1) OPM's regulatory authority over insurance carriers and (2) the possibility of a conflict from "applying the laws of multiple states." 2017 WL 4250514, at *10–11. As just explained, a federal agency's authority to regulate is insufficient to show conflict preemption. Likewise, the cases cited above show that

the mere possibility of differences among the consumer protection laws of the various states has not been a basis to hold state laws preempted. *See also Empire HealthChoice*, 396 F.3d at 141 (rejecting insurer's attempt "to speculate about the various harms that 'might' result from state-by-state adjudication of suits . . . under FEHBA-authorized contracts," absent some showing of an "actual conflict"); *id.* at 142 (rejecting notion that "a conflict necessarily exists between the operation of state contract law and the federal interests in uniformity underlying FEHBA"). So too here, Anthem points to nothing other than speculation to conclude that applying state law will conflict with federal law. In any event, "consumer protection statutes from states across the country" all focus on whether the misrepresentation "plausibly could deceive a reasonable consumer." *Hoffman v. Kraft Heinz Foods Co.*, 2023 WL 1824795, at *9 (S.D.N.Y. Feb. 7, 2023) (internal quotation marks omitted). And insofar as *Mahajan* relied on legislative history to conclude that FEHBA was intended to displace state law, 2017 WL 4250514, at *10, it omitted that the Second Circuit construed the same legislative history *not* to displace "generally applicable state law that may have an effect on benefits or coverage in some cases." *Empire HealthChoice*, 396 F.3d at 149 n.16.[6]

Plaintiffs' claims are therefore not preempted by implication.

III. Plaintiffs Were Not Required To Exhaust Administrative Remedies

Anthem's argument that Plaintiffs failed to exhaust administrative remedies has no basis in the governing regulations. Mot. at 16–20. Those regulations, by their plain terms, mandate exhaustion only when seeking review of a denied health benefits claim. Plaintiffs are not seeking review of a denied health benefits claim. Indeed, there were no claims to deny since Plaintiffs

[6] Anthem is likewise wrong to rely on *Kight v. Kaiser Found.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999), as that case applied the Fourth Circuit's *Caudill* decision, which the Second Circuit expressly rejected in *Empire HealthChoice*, 396 F.3d at 141. *See* Mot. at 14.

could not find providers to furnish timely medical care in the first place due to Anthem's grossly inaccurate provider directory. Anthem's argument that exhaustion was required misconstrues the regulations governing administrative exhaustion. Courts have rejected similar arguments for exhaustion in analogous circumstances.

Federal employees are required to exhaust administrative remedies related to their health insurance benefits only in particular circumstances. The regulation requires that "[a]ll health benefits claims" be submitted to the insurance carrier and, if the carrier denies the claim, the denial may be appealed to OPM. 5 C.F.R. § 890.105(a)(1).[7] At the end of that process, if OPM denies the claim, the federal employee "may seek judicial review of OPM's final action on the denial of a health benefits claim," and "[a] legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors." *Id.* § 890.107(c). "The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." *Id.* An action against OPM "to recover on a claim for health benefits" cannot be brought "prior to exhaustion of the administrative remedies provided in § 890.105"—*i.e.*, before the denial of a health benefits claim has been exhausted. *Id.* § 890.107(d); *see also Empire HealthChoice*, 547 U.S. at 696 (stating that "OPM's regulation instructs enrollees who seek to challenge *benefit denials* to proceed in court against OPM 'and not against the carrier or carrier's subcontractors'" (emphasis added) (quoting 5 C.F.R. § 890.107(c))).

By their plain terms, these regulations mandate exhaustion only when a plaintiff sues to challenge the denial of a health benefits claim. *See Safe Haven Home Care, Inc. v. U.S. Dep't*

[7] A "claim" is defined as "a request for (i) payment of a health-related bill; or (ii) provision of a health-related service or supply." 5 C.F.R. § 890.101(a).

Health & Hum. Servs., 130 F.4th 305, 321 (2d Cir. 2025) (holding that "the plain meaning of the regulation" controls); *Kisor v. Wilkie*, 588 U.S. 558, 573 (2019) (courts should apply "all the standard tools of interpretation" to regulations). But Plaintiffs are not bringing suit to challenge benefit denials, since there were none. Instead, the gravamen of their suit is that Anthem's misrepresentations regarding the providers that were supposedly available to its enrollees caused Plaintiffs to enroll in Anthem's plan (instead of better or cheaper options), prevented them from receiving timely medical care, and forced one of them to incur out-of-network costs. Compl. ¶¶ 74–83, 89–96. The regulations do not require exhaustion in these circumstances, which do not involve a "denial of a health benefits claim" but instead involve other injuries. *Cf. In re Anthem, Inc. Data Breach Litig.*, 162 F. Supp. 3d 953, 1008–09 (N.D. Cal. 2016) (holding that data breach claim against Anthem did not need to be exhausted because Plaintiffs' claims did not fall within definition of a denial of "health benefits").

Anthem's contrary arguments are divorced from the text of the regulations, ignore analogous Second Circuit precedent, and mischaracterize out-of-circuit precedent. Anthem insists that Plaintiffs ought to have pursued claims with the insurance carrier and OPM because they are "the sort of benefits disputes that must be addressed through FEHBA's mandatory administrative dispute process." Mot. at 19. But Anthem points to no language in the regulations supporting that assertion. To the contrary, the Second Circuit has held in the context of ERISA exhaustion that "where a plaintiff reasonably interprets the plan terms not to require exhaustion and, as a result, does not exhaust her administrative remedies, the case may proceed in federal court." *Kirkendall v. Halliburton, Inc.*, 707 F.3d 173, 180 (2d Cir. 2013). Thus, in *Kirkendall*, the Court held that exhaustion was not required because plaintiff sought clarification of "future benefits," while the plan documents required her to dispute only the denial of an immediate "benefit claim." *Id.* at

179–80. So too here, the plain language of FEHBA's regulations mandates that an insured exhaust her remedies only when she contests the denial of a health benefits claim, which is not what Plaintiffs are doing here. Plaintiffs thus had no administrative remedies to exhaust for the injuries they seek to remedy in this lawsuit, and certainly were not on clear notice that exhaustion was required. *See id.* at 179 ("Implicit in the exhaustion requirement is the condition that a plaintiff must have an administrative remedy to exhaust."); *Weyand v. Phia Grp. LLC*, 823 F. App'x 51, 52 (2d Cir. 2020) ("we do not require plaintiffs to exhaust their administrative remedies where there is no administrative remedy to exhaust").

Unable to confront the plain text of the regulations, Anthem instead engages in a sleight of hand. Anthem argues that Plaintiffs should have disregarded its useless provider directory, found mental health providers on their own, sought care from those providers, paid out of pocket, and then waited to see if Anthem would eventually reimburse them. Mot. at 18–19. This callous argument should not be taken seriously. First, following such a procedure would not have actually remedied Plaintiffs' injuries, such as the mental health problems they suffered while trying in vain to find someone to treat them. Second, the question is not whether Plaintiffs could have taken the steps suggested by Anthem, but whether they were *required* to do so under the law. *Cf. Ross v. Blake*, 578 U.S. 632, 639 (2016) (holding that PLRA's "mandatory language" required administrative exhaustion); *McQuillin v. Hartford Life & Accident Ins. Co.*, 36 F.4th 416, 420–21 (2d Cir. 2022) (applying "plain meaning" and "structure" of ERISA regulations to conclude that plaintiff was not required to further exhaust administrative remedies). Nothing in the statute or regulations suggests that Plaintiffs were required to exhaust anything other than a claim for the

denial of health benefits.[8]

Remarkably, with one inapposite exception, none of the cases cited by Anthem involved administrative exhaustion. Rather, those cases assessed whether, if a claim were preempted by FEHBA or ERISA, the plaintiff would have an alternative remedy available. Thus, in *Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390 (9th Cir. 2002), the Ninth Circuit concluded that a state-law claim was preempted under FEHBA—applying reasoning inconsistent with Second Circuit case law discussed above—and held that plaintiffs could pursue alternative remedies against OPM. *Id.* at 394–99. But that is not the same thing as holding that exhaustion is required where, as here, state-law claims are not preempted. Similarly, the ERISA cases cited by Anthem assessed whether claims were preempted under ERISA's distinct "complete preemption" framework. Accordingly, in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Court held that a plaintiff's state-law causes of action—challenging an insurer's decision "not to provide coverage for certain treatment and services" prescribed by patients' doctors—could be removed to federal court because the claims involved the administration of the ERISA plan. *Id.* at 204–05, 213–14. That case is doubly inapposite because (1) Plaintiffs here are not pursuing claims for denial of health benefits, and (2) the Supreme Court has held that, unlike ERISA, FEHBA does not completely preempt state law. *See Empire HealthChoice*, 547 U.S. at 698.[9]

[8] Anthem alternatively suggests that Plaintiffs could have sued OPM under 5 C.F.R. § 890.107(b), which authorizes suits "to review the legality of OPM's regulations." Mot. at 16. The suggestion is puzzling because Plaintiffs do not challenge any of OPM's regulations, but rather challenge Anthem's unlawful misrepresentations about its provider network.

[9] *Cicio v. Vytra Healthcare*, cited by Anthem, was likewise a case assessing whether ERISA plaintiffs had "alternative means" to vindicate their rights such that (1) ERISA's complete preemption framework applied and (2) federal jurisdiction was proper. 321 F.3d 83, 94 (2d Cir. 2003), *cert. granted, judgment vacated*, 542 U.S. 933 (2004), *reinstated in relevant part*, 385 F.3d 156 (2d Cir. 2004) (per curiam). *See* Mot. at 17.

The sole case cited by Anthem involving administrative exhaustion, *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588 (2d Cir. 1993), is not on point. Mot. at 20. In *Kennedy*, the Second Circuit construed a prior version of FEHBA's exhaustion regulation, which said that an insured "may" ask the insurance carrier and OPM to review a denied claim. 989 F.2d at 593 (quoting 5 C.F.R. § 890.105(a) (1992)). The Court deferred to OPM's view that the regulation mandated exhaustion of the denial of a benefits claim before the insured filed suit, even though the regulation used permissive language. *Id.* at 593–94.[10] But Anthem points to no OPM interpretation of the regulation—and Plaintiffs are aware of none—mandating exhaustion in *the present circumstances*, *i.e.*, where a plaintiff is not challenging the denial of a health benefits claim. And even if such an interpretation existed, the Supreme Court has recently held that courts should not defer to administrative interpretations of regulations when, as here, the plain meaning of the regulation is clear. *See Kisor*, 588 U.S. at 573.

In short, Plaintiffs were not required to exhaust administrative remedies before filing suit because they were not challenging the denial of benefits claims.[11]

IV. Plaintiffs May Pursue Their Claim for Breach of Contract

Finally, Plaintiffs may pursue their claim for breach of contract as intended beneficiaries of OPM's contract with Anthem. That contract requires Anthem to comply with federal law mandating insurers to update their provider directory frequently and to remove those providers

[10] As Anthem correctly observes, the regulation has since been amended to make explicit that an insured must exhaust the denial of a health benefits claim "before seeking judicial review of the denied claim." 5 C.F.R. § 890.105(a); *see* Mot. at 20 n.10.

[11] If, however, the Court concludes that Plaintiffs should have exhausted their claims, the dismissal should be without prejudice to Plaintiffs' refiling after administrative remedies have been exhausted. *See Berry v. Kerik*, 366 F.3d 85, 87 (2d Cir. 2004) (noting that "dismissal without prejudice is appropriate" when plaintiff still has the ability to exhaust).

who the insurer cannot reach. Compl. ¶¶ 118–21; *see* Dkt. 26-2 at 54; Dkt. 26-8 at 10. Anthem does not dispute that Plaintiffs have adequately alleged that Anthem breached this provision of the contract. Rather, Anthem's sole argument is that Plaintiffs are not intended third-party beneficiaries under a "heightened standard" applicable to government contracts intended to benefit the public. Mot. at 21. Decades of precedent make clear that Anthem is wrong. Plaintiffs are intended third-party beneficiaries under the contract, and Plaintiffs need not satisfy a special standard because they do not seek to enforce a government contract benefiting the public but rather are enforcing a contract intended to benefit them as government employees enrolled in a specific health insurance plan. In any event, specific contractual language indicates that Plaintiffs have the right to enforce these provisions.

Anthem appears to concede—correctly—that Plaintiffs are third-party beneficiaries of its contract with OPM and disputes only whether Plaintiffs are *intended* third-party beneficiaries who can enforce the contract. Mot. at 21–22. But the Second Circuit has all but answered that question in the affirmative. As the Court explained, "[g]roup insurance policies, unlike individual insurance policies, are contracts for the benefit of third parties. Under a group insurance program, a central entity—the group—enters into a contract with an insurance provider and acts as the policyholder. Members of the group are the third-party beneficiaries of that contract." *Dubuisson v. Stonebridge Life Ins. Co.*, 887 F.3d 567, 569 (2d Cir. 2018). OPM enters into contracts with insurance carriers like Anthem to provide insurance services directly to federal employees, and "a third party will be deemed an intended beneficiary where performance is rendered directly to it under the terms of the contract." *Levin v. Tiber Holding Corp.*, 277 F.3d 243, 249 (2d Cir. 2002); *see* Restatement (Second) of Contracts § 302 ("a beneficiary of a promise is an intended beneficiary if . . . the circumstances indicate that the promisee intends to give the beneficiary the benefit of the promised

performance"); 5 U.S.C. § 8905(a) (providing that "[a]n employee may enroll in an approved health benefits plan").

OPM's contract with Anthem, of course, makes this explicit: as anyone who has ever enrolled in employee health insurance knows, the insurer provides health insurance benefits to the employee, not the employer. *See, e.g.*, Dkt. 26-2 at 42 (2022 contract requiring insurer to "provide the benefits as described in the agreed upon brochure text found in Appendix A"); Dkt. 26-13 at 7 (2022 brochure text explaining to enrollees the benefits available to them and stating: "If you are enrolled in this Plan, you are entitled to the benefits described in this brochure."). This rights-conferring language—along with the insurer's provision of services directly to federal employees—is sufficient to make federal employees intended third-party beneficiaries of OPM's contract with the relevant insurance carrier. *See Levin*, 277 F.3d at 249; *Flickinger v. Harold C. Brown & Co., Inc.*, 947 F.2d 595, 600 (2d Cir. 1991) ("Where performance is to be rendered directly to a third party under the terms of an agreement, that party must be considered an intended beneficiary." (internal quotation marks omitted)). Intended third-party beneficiaries, like Plaintiffs here, may pursue claims for breach of contract directly against the promisor—here, Anthem. *Id.*; *see* Restatement (Second) of Contracts § 302.[12]

Anthem's only argument is that Plaintiffs cannot meet a heightened standard for government contracts intended to benefit the general public. Mot. at 21–23. That standard does not apply here, and Plaintiffs would satisfy it even if it did. Anthem relies on the principle that government contracts designed to benefit the public cannot be enforced by members of the public

[12] Anthem relies principally on cases that found no third-party beneficiary status because the contract expressly stated that it did not create rights in third parties. *See, e.g.*, *Hillside Metro Assocs., LLC v. JPMorgan Chase Bank*, 747 F.3d 44, 49 (2d Cir. 2014). By contrast, the contract here contains no such language and instead expressly confers rights on enrollees.

as third-party beneficiaries, absent specific contractual language showing that enforcement by members of the public was contemplated. *Id.*; *see Fero v. Excellus Health Plan, Inc.*, 236 F. Supp. 3d 735, 767–69 (W.D.N.Y. 2017) (concluding that, under this "heightened standard," FEHBA enrollees could not sue to enforce OPM contractual provisions regarding data security).

But that principle does not apply here because Plaintiffs are not seeking to enforce a contract intended to benefit the *public*; rather, Plaintiffs seek to enforce a contract benefiting a narrower class of federal employees who chose to enroll in Anthem's health insurance plan. *See* Restatement (Second) of Contracts § 313 (stating that higher standard applies when promisor contracts "to do an act for or render a service to the public"). Courts around the country have held that when government contracts benefit a defined class of people, that defined class can sue to enforce the contract as third-party beneficiaries. *See, e.g.*, *Eldridge v. Shelby Cnty.*, 2020 WL 1962988, at *11–12 (W.D. Tenn. Apr. 23, 2020) (holding government employee an intended beneficiary of government employee insurance policy); *McNeill v. N.Y.C. Hous. Auth.*, 719 F. Supp. 233, 248–49 (S.D.N.Y. 1989) (Walker, J.) (holding Section 8 tenants were intended third-party beneficiaries of contracts between landlords and housing authority and could enforce those contracts); *Gonzalez v. St. Margaret's House Hous. Dev. Fund Corp.*, 620 F. Supp. 806, 810 (S.D.N.Y. 1985) (Leval, J.) (same, for contract between landlord and federal government); *Holbrook v. Pitt*, 643 F.2d 1261, 1271 (7th Cir. 1981) (same); *accord German v. Fed. Home Loan Mortg. Corp.*, 885 F. Supp. 537, 578 (S.D.N.Y. 1995) (adopting *McNeill*'s reasoning that tenants are third-party beneficiaries of Section 8 contracts); *Audio Odyssey, Ltd. v. United States*, 255 F.3d 512, 520–22 (8th Cir. 2001) (holding borrower was a third-party beneficiary of Small Business Administration guaranty agreement because borrower was "clearly part of a class intended to be benefitted by this agreement"). Likewise here, Plaintiffs need not satisfy a heightened standard to

establish their status as intended third-party beneficiaries because they are part of a defined class of individuals for whom Anthem contracted to provide benefits. As explained above, Plaintiffs may sue to enforce the contract because Anthem provides services directly to them.

In any event, Plaintiffs satisfy the more demanding (and inapplicable) standard urged by Anthem here. Anthem insists that there is no "specific language in the contract demonstrating an intent to permit a third party to sue to enforce the contract's terms." Mot. at 22. But OPM's contract with Anthem expressly contemplates that federal employees can sue to enforce their contractual rights. *See* Dkt. 26-2 at 51 (authorizing lawsuits regarding denials of health benefits). Moreover, Anthem is wrong to suggest that there is no contractual language authorizing suit against insurers for violating the provisions of federal law governing provider directories that are incorporated in Anthem's contract with OPM. Mot. at 23. To the contrary, the contract provides that insurance carriers like Anthem "shall comply with requirements described in" various statutory subsections, including section 720 of ERISA, "in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections." Dkt. 26-8 at 10; *see* Compl. ¶¶ 118, 120. Section 720 of ERISA, codified at 29 U.S.C. § 1185i, imposes the very requirements to update and verify the provider directory that Plaintiffs seek to enforce here. And no one can dispute that this statutory provision provides a private right of action. *See* 29 U.S.C. § 1132(a)(3) (permitting ERISA plan participants "to enjoin any act or practice which violates any provision of this subchapter"). Because OPM's contract incorporates section 720 of ERISA and other subsections "in the same manner as such provisions apply" in their organic statutes, the contract brings with it the insured's right to enforce those rights as she would have in a suit governed by ERISA. *See SEC v. Govil*, 86 F.4th 89, 102 & n.12 (2d Cir. 2023) (explaining that cross reference to statute "brings the old

soil with it," such that similar remedies apply as in cross-referenced statute (internal quotation marks omitted)). The Court need not reach this issue, however, if it concludes that the heightened standard urged by Anthem is inapplicable here (which it is).

In short, under any standard, Plaintiffs are third-party beneficiaries of Anthem's contract with OPM and may enforce their rights against Anthem.

V. The Court Should Take No Action With Respect To Damages

Anthem briefly argues that the Court should "strike" Plaintiffs' allegations relating to benefit-of-the-bargain damages. Mot. at 23–24. But that is a procedurally improper request. "A motion to dismiss is addressed to a claim—not to a form of damages. As damages are not an independent cause of action, a motion to dismiss these damages is procedurally premature." *Chalas v. Pork King Good*, 673 F. Supp. 3d 339, 344–45 (S.D.N.Y. 2023) (internal quotation marks and citations omitted); *accord Monroe v. Buzzfeed, Inc.*, 2024 WL 4350964, at *8 (S.D.N.Y. Sept. 30, 2024) ("Motions to dismiss are properly addressed to causes of action, not forms of relief."). In any event, Plaintiffs do not concede that *all* "benefit-of-the-bargain" damages are unavailable, but only, at most, those pertaining to whether the premiums approved by the federal government were reasonable. If the case proceeds to trial, Plaintiffs are amenable to conferring with Anthem to determine if the parties can agree on jury instructions on the appropriate scope of damages.

CONCLUSION

For the foregoing reasons, Anthem's motion to dismiss should be denied in its entirety. If the Court dismisses any of Plaintiffs' claims in whole or in part, Plaintiffs respectfully request leave to amend. *See Loreley Financing (Jersey) No. 3 Ltd. v. Wells Fargo Secs., LLC*, 797 F.3d 160, 190–91 (2d Cir. 2015) (explaining that plaintiffs should ordinarily be granted leave to amend if Court grants motion to dismiss).

Dated: New York, NY
May 2, 2025

Respectfully submitted,

WALDEN MACHT HARAN & WILLIAMS LLP

By: /s/ *Jacob Gardener*

Jacob Gardener
Samuel Rosh
250 Vesey Street, 27th Floor
New York, NY 10281
Tel: (212) 335-2030
jgardener@wmhwlaw.com
srosh@wmhwlaw.com

POLLOCK COHEN LLP

Steve Cohen
Anna Menkova
111 Broadway, Suite 1804
New York, NY 10006
Tel: (646) 517-0542
scohen@pollockcohen.com
anna@pollockcohen.com

Attorneys for Plaintiffs

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 2.B of the Court's Individual Rules and Practices in Civil Cases, I hereby certify that this motion complies with the Court's word-count limitations and contains 8,331 words, exclusive of the caption, table of contents, table of authorities, signatures blocks, or any required certificates.

/s/ Jacob Gardener

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 second day of May 2025.

/s/ Jacob Gardener