UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH GREENE, PAMELA MAZZA, and DEBORAH SCHUTT on behalf of themselves and all others similarly situated, Plaintiffs, v. HEALTHFIRST PHSP, INC., Defendant.	Case No. 25-cv-09058 **FIRST AMENDED CLASS ACTION COMPLAINT** **JURY TRIAL DEMANDED**

Plaintiffs Joseph Greene, Pamela Mazza, and Deborah Schutt bring this class action for damages, equitable relief, and injunctive relief against Healthfirst PHSP, Inc. ("Healthfirst" or "Defendant"). Plaintiffs allege the following based upon personal information as to allegations regarding themselves, their own investigation, and the investigation of their counsel, and on information and belief as to all other allegations.

INTRODUCTION

1. There is a mental health crisis in this country and in this state. It is afflicting men and women, children and adults, and people of all income levels and backgrounds. And it is exacerbated by Defendant, which has been misleading vulnerable individuals in need of qualified mental health providers by publishing a grossly inaccurate directory of doctors and therapists. Defendant maintains what is known as a "ghost network."

2. Ghost networks are directories of supposedly available, in-network providers that contain so many incorrect or duplicative entries that the network is largely illusory.

3. When there are very few—or no—accessible, available doctors in Defendant's network, the network does not comply with state and federal network adequacy laws. Such grossly

inaccurate listings in a directory also violate the No Surprises Act, the Mental Health Parity and Addiction Equity Act, Defendant's contractual obligations to Plaintiffs (which, among other things, require Defendant to comply with state and federal law), and New York's consumer protection laws (General Business Law §§ 349 and 350), New York Insurance Law § 4226, and the New York State Department of Financial Services' standards.

4. Defendant engages in deceptive business practices by knowingly publishing an inaccurate and misleading provider directory. It does so for several reasons: 1) a robust provider network is attractive to potential customers; 2) a seemingly robust directory of providers gives Defendant the appearance of compliance with state and federal network adequacy laws (without the costs associated with creating and maintaining an adequate network and accurate directory); and 3) when members forego care after a time-consuming and frustrating provider search, Defendant does not have to pay for the care they would have received.

5. By publishing a provider directory in which the vast majority of providers do not exist, cannot be contacted through the information provided, are not actually in-network with Defendant, and/or are not accepting new patients, Defendant actively harms its members. When Defendant misrepresents its network, members like Plaintiffs pay inflated premiums for an insurance plan that does not actually offer an adequate provider network to meet their needs. Many members, like Plaintiffs, have no choice but to utilize out-of-network doctors, incurring thousands of dollars in expenses.

6. Plaintiffs' insurance policies claim to cover mental health care with a robust network of available mental health providers made available by Defendant. In reality, that network is threadbare: there are very few mental health providers in New York who actually take the

insurance, are in-network, and accept new patients. Thus, the promised coverage is largely non-existent.

7. The harms are not just financial. They also exacerbate members' mental health problems. The people using Defendant's provider directory are often desperate for mental health care for themselves or their loved ones. Members searching for care often spend countless hours calling providers that Defendant has represented as available, accessible, and in-network, only to find out that the providers do not participate in Defendant's network, do not offer the services listed in Defendant's provider directory, are not qualified to provide those services, or cannot be reached at the phone number listed by Defendant.

8. Some members, like Plaintiffs, are forced to delay treatment while struggling to find a provider. Others abandon their search for care, resulting in serious, potentially life-threatening consequences. Thus, the coverage promised by Defendant is largely illusory.

JURISDICTION AND VENUE

9. Federal law provides an essential element of Plaintiffs' claims. Accordingly, this Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331.

10. Venue is proper in this Judicial District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claim occurred in this Judicial District. Venue is also proper under 18 U.S.C. § 1965(a) because Defendant transacts substantial business in this Judicial District.

THE PARTIES

I. Plaintiffs

11. Plaintiff Joseph Greene is a resident of Bronx County, New York. He was enrolled in the Healthfirst Gold Leaf Premier plan from January 2023 to March 2024 and the Healthfirst

Essential Plan 200-250 from April 2024 to August 2025. He has been enrolled in the Healthfirst Essential Plan 1 since September 2025.

12. Plaintiff Pamela Mazza is a resident of Bronx County, New York. She was enrolled in the Healthfirst Medicaid Managed Care plan from approximately January 2024 to September 2025. She has been enrolled in the Healthfirst Essential Plan 2 since September 2025.

13. Plaintiff Deborah Schutt is a resident of New York County, New York. She was enrolled in the Healthfirst Gold Leaf Premier plan from October 2022 through December 2023. She was enrolled in the Healthfirst Silver Leaf Premier Plus plan from January 2024 through December 2025. She has been enrolled in the Healthfirst Bronze Leaf Premier plan since January 2026.

II. Defendant

14. Defendant Healthfirst PHSP, Inc. ("Healthfirst") is a not-for-profit corporation registered to do business in New York. It administers the Healthfirst Essential Plans, the Healthfirst Leaf Plans, and the Healthfirst Medicaid Managed Care Plan ("the Plans").

BACKGROUND & CONTEXT

III. The Mental Health Crisis in America

15. There is a mental health crisis in the United States. According to the National Institute of Mental Health, an estimated 59.3 million adults in the U.S.—approximately 23.1% of adults—struggle with mental illness.[1] Mental health problems are even more prevalent in younger adults, with 36.2% of adults ages 18–25 and 29.4% of adults ages 26–49 reportedly having a

[1] National Institute of Mental Health, *Mental Illness Statistics*, https://www.nimh.nih.gov/health/statistics/mental-illness.

mental illness. Despite this prevalence, roughly half (49.4%) of the 59.3 million adults living with mental illness have not received mental health treatment within the last year.[2]

16. In 2022, an estimated 15.4 million adults in the U.S. (6% of the adult population) had a *serious* mental illness, defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[3] Despite the potentially disabling or even life-threatening effects of forgoing treatment, one third of those with serious mental illness do not receive treatment.[4]

17. According to the Centers for Disease Control and Prevention ("CDC"), among adolescents aged 12 to 17 years old, 20.9% have had a major depressive episode; among high school students, 36.7% have had persistent feelings of sadness or hopelessness, and 18.8% have attempted suicide.[5]

18. With the rates of pediatric self-harm and suicide rising dramatically,[6] the Surgeon General of the United States has described mental health as "the defining public health crisis of

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[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] Rebecca H. Bitsko *et. al.*, *Mental Health Surveillance Among Children – United States, 2013–2019*, Ctrs. for Disease Control and Prevention (2022), https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm.

[6] Bommersbach et al., *National Trends in Mental Health-Related Emergency Department Visits Among Youth, 2011-2020*, J. of the Am. Med. Ass'n (May 2, 2023), https://pubmed.ncbi.nlm.nih.gov/37129655/ (finding a 57 percent increase in suicide among young Americans from 2009 to 2019, and a staggering 329 percent increase in pediatric self-harm visits from 2007 to 2016).

our time,"[7] and urged that "every child ha[ve] access to high-quality, affordable, and culturally competent mental health care."[8]

19. Despite the "profound" consequences of untreated mental illness in children and adolescents, which are associated with "school failure, teenage pregnancy, unstable employment, substance use, violence including suicide and homicide, and poor medical outcomes,"[9] the CDC estimates that only approximately 20 percent of children with a mental, emotional, or behavioral disorder receive care from a specialized mental health provider.[10]

IV. Federal and State Requirements for Health Insurers

A. Insurers Must Ensure Accuracy of Provider Directories

20. Federal and state laws and regulations have been promulgated to protect consumers from the harms of ghost networks.

21. The No Surprises Act, which became effective in 2022, requires insurers to update and verify their plans' provider directories at least every 90 days.[11] Where plans are unable to verify provider data, they must establish a procedure to remove unverified providers from their

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[7] Matt Richtel, *The Surgeon General's New Mission: Adolescent Mental Health*, N.Y. TIMES, (Mar. 21, 2023), https://www.nytimes.com/2023/03/21/health/surgeon-general-adolescents-mental-health.html.

[8] *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, Off. of the Surgeon Gen. at 12 (2021), https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[9] School-Based Mental Health: Pediatric Mental Health Minute Series, Am. Academy of Pediatrics, https://www.aap.org/en/patient-care/mental-health-minute/school-based-mental-health/.

[10] Ctrs. for Disease Control and Prevention, *Improving Access to Children's Mental Health Care*, https://archive.cdc.gov/#/details?q=mproving%20Access%20to%20Care,%20Children%E2%80%99s%20Mental%20Health%22&start=0&rows=10&url=https://www.cdc.gov/childrensmentalhealth/access.html.

[11] 42 U.S.C. § 300gg-115(a)(2).

directories.[12] Health plans must also update provider information within two business days of receiving an update from a provider.[13] When a member telephonically requests information about whether a provider is in-network, the plan must respond within one business day of the request.[14]

22. The Affordable Care Act likewise requires a health insurance company participating in the Affordable Care Act Marketplace to "publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible" to enrollees and prospective enrollees.[15] Further, the insurance provider must "identify providers that are not accepting new patients."[16]

23. In New York, state law requires insurers to take more rigorous steps to ensure that their provider directories are accurate. Health insurers are required to update their provider directories within 15 days of the "addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation"—and otherwise update their plans' directories annually.[17] Managed care organizations are required to make these updates quarterly and to notify members of updates annually.[18] State law also requires health plans to include in their directories

[12] *Id.*

[13] *Id.*

[14] 42 U.S.C. § 300gg-115(a)(3).

[15] 45 C.F.R. § 156.230(b)(2).

[16] 45 C.F.R. § 156.230(b)(1).

[17] N.Y. Ins. Law §§ 3217-a(a)(17); 4324(a)(17); N.Y. Pub. Health Law § 4408(1)(r) .

[18] 10 N.Y.C.R.R. 98-1(16)(i).

whether a provider is accepting new patients and any restrictions on the availability of a provider's services.[19]

24. Furthermore, Section 4226 of the New York State Insurance Law prohibits insurers from issuing or circulating "any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts."[20] When an insurer is found to have made such a misrepresentation, "it shall not be presumed that the insured knew or knows of any of the provisions or benefits contained in any insurance policy or contract."[21] Health maintenance organizations must also ensure that "all information disseminated to the public . . . be strictly factual in nature and accurate in all respects and shall not in any way be misleading to the public."[22]

25. Under New York law, when a health plan member receives a bill for out-of-network services after relying on the insurer's representation that the provider was in-network, the insurance plan is required to pay for the services and cannot charge the member more than their in-network cost sharing obligation regardless of whether the plan covers out-of-network services.[23]

26. These federal and state laws reflect that governments recognize the harmful consequences of inaccurate provider directories. Despite these legislative efforts to shield consumers from ghost networks, surprise bills, and inadequate in-network care, Defendant continues to violate these laws.

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[19] *Id*.

[20] N.Y. Ins. Law § 4226(a)(1).

[21] N.Y. Ins. Law § 4226(c).

[22] N.Y. Pub. Health Law § 4405(10).

[23] N.Y. Ins. Law §§ 3217-b(n); 4325(o).

B. Insurers Must Have an Adequate Network of Providers

27. Federal and state laws also require health plans to offer a network that includes an adequate number of in-network providers to meet members' needs.

28. The Affordable Care Act first established this network adequacy framework, requiring that all Qualified Health Plans provide 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."[24]

29. In addition, the Mental Health Parity and Addiction Equity Act ("MHPAEA"), 42 U.S.C. § 300gg-26, incorporated into the Affordable Care Act via 45 C.F.R. § 156.115, provides that mental health and substance use disorder benefits must not be provided on less favorable terms than medical and surgical benefits, specifically with respect to annual, aggregate, or lifetime limits on coverage, financial requirements, treatment limitations, and out-of-network coverage.[25]

30. MHPAEA regulations provide that "all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy."[26]

31. New York law also requires health insurers to "ensure that the network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of

[24] 45 C.F.R. § 156.230(a)(1)(ii).

[25] 29 U.S.C. §1185a(a); 42 U.S.C. § 300gg-26(a).

[26] Ctrs. for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (2023), https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity; *see also* 29 C.F.R. 2590.712(c)(4).

providers sufficient to render the services covered under the policy or contract."[27] The New York Department of Financial Services advises that mental health providers should be accessible within 30 minutes by public transportation in metropolitan areas and/or 30 minutes or 30 miles by public transportation or by car in non-metropolitan areas.[28] When a member is unable to access an appropriate provider through the network, the insurer is required to provide a referral to an out-of-network provider at the in-network cost-sharing amount.[29]

32. By inflating their provider directories with inaccurate listings, insurers appear to meet federal and state network adequacy requirements when, in reality, they do not.[30]

33. Before and throughout Plaintiffs' enrollment in Defendant's health insurance, Defendant has violated and continues to violate federal and state laws requiring network adequacy.

[27] N.Y. Ins. Law § 3241(a)(1).

[28] *See Network Adequacy Submission Instructions and Standards*, N.Y. State Dep't of Fin. Servs. (September 9, 2025), https://www.dfs.ny.gov/apps_and_licensing/health_insurers/network_adequacy_reqs_standards_submission_instructions.

[29] N.Y. Ins. Law § 4804(a).

[30] *Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks*, U.S. Senate Fin. Comm. (May 3, 2023), https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-directory-accuracy-to-reduce-the-prevalence-of-ghost-networks (hereinafter "Senate Hearings on Mental Health Care").

V. Ghost Networks

34. The harms of a mental health ghost network have been investigated and confirmed, including by *The New York Times*,[31] *The Washington Post*,[32] academics,[33] the American Medical Association,[34] the Government Accountability Office,[35] and more.[36]

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[31] Jay Hancock, *Insurers' Flawed Directories Leave Patients Scrambling for In-Network Doctors*, N.Y. TIMES (Dec. 3, 2016), https://www.nytimes.com/2016/12/03/us/inaccurate-doctor-directories-insurance-enrollment.html.

[32] Katherine Ellison, *73 doctors and none available: How ghost networks hamper mental health care*, WASH. POST (Feb. 19, 2022), https://www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network/.

[33] *See, e.g.*, Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE L. & POL'Y REV. 78 (2021).

[34] *Improving Health Plan Provider Directories*, CAQH & AM. MED. ASS'N., 3, https://www.caqh.org/sites/default/files/other/CAQH-AMA_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf (finding that "more than half of patients use [the provider directory] to select a physician.") (hereinafter "Improving Health Plan Provider Directories").

[35] *Mental Health Care Access Challenges for Covered Consumers and Relevant Federal Efforts*, U.S. Gov't Accountability Office, Report to the Chairman, Comm. on Fin., U.S. Senate, 2, (Mar. 2022), https://www.gao.gov/assets/gao-22-104597.pdf.

[36] *See, e.g.*, Ellison, supra n.32; Jack Turban, *Ghost networks of psychiatrists make money for insurance companies but hinder patients' access to care*, Stat News (June 17, 2019), https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/; *Online Provider Directory Review Report*, Ctrs. for Medicare & Medicaid Servs., 1, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf; Cama et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, INT'L J. HEALTH SERV. 47(4) (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/; Malowney et al., *Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities*, Psychiatry Online (2015), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400051; Zhu et al., Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access in Oregon Medicaid, Health Affairs 41(7) (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00052; Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, Health Affairs 39(6) (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

35. As explained by a Yale Law & Policy Review article on ghost networks, the effects of Defendant's ghost network are far-reaching and damage the very structure of our health care system:

> Directory errors cost consumers money and erode regulatory consumer safeguards. They deceive consumers about the value of the coverage they are purchasing by concealing plans' actual provider networks, subjecting consumers to predatory billing practices, and breaking the link between consumer choices and plan practices that undergirds much of the American health insurance regulatory structure.[37]

A. The United States Senate Finance Committee Ghost Networks Hearings

36. In May 2023, the United States Senate Finance Committee held a hearing on ghost networks. One testifying witness summarized her Sisyphean experience trying to find a mental health provider through her insurance plan's directory:

> Calling psychiatrists within D.C. and Maryland, selected out of what was like a digital white-pages phone book, turned into one rejection after another. . . . I spent countless days and hours scouring the network, despite working long hours in a high-level management position. When was there time to find a psychiatrist? I had to make the time, though, as my job, and more importantly my life, depended on it.[38]

37. People seeking a mental health provider on a ghost network spend countless, difficult hours searching for care, which is extremely burdensome for a person who may be experiencing a mental health emergency. As Dr. Robert Trestman, representing the American Psychiatric Association, testified:

> For those who are healthy and well educated, going through an inaccurate provider list and being told repeatedly that "we are not taking new patients," "this provider has retired," "we no longer accept your

[37] Burman, supra n. 33, at 85.

[38] Senate Hearings on Mental Health Care (Statement of Keris Jän Myrick at 2–3), available at https://www.finance.senate.gov/imo/media/doc/barriers_to_mental_health_care_improving_provider_directory_accuracy_to_reduce_the_prevalence_of_ghost_networks.pdf.

> insurance," or leaving a message with no one returning the call is at best frustrating. For people who are experiencing significant mental illness or substance use disorders, the process . . . is at best demoralizing and at worst set up to precipitate clinical deterioration and a preventable crisis. Many are already experiencing profound feelings of worthlessness, fear, grief from loss and trauma, and/or the impact of substance use; some are in crisis and suicidal. . . . Even when they make the effort to reach out to find help, something that can be very difficult anyway, their efforts to cull through an inaccurate provider list results in more rejection and failure, exacerbating these feelings. Some give up looking for care. Others delay care.[39]

38. When people in need are unable to find an in-network mental health provider, urgent mental health treatment is often delayed and, at worst, abandoned completely. Others seeking care rely on the directory to find a provider, only to face significant, unexpected costs when it becomes clear that the provider is not actually covered by their plan. And, in other cases, people urgently seeking care knowingly settle for seeing an out-of-network provider at great expense because they desperately need help and it is their only option.

39. Though the effects of a ghost network are far-reaching and complex, the wrongful conduct at issue is simple: a ghost network misleads consumers. As Senator Ron Wyden stated in his opening remarks:

> [W]hen insurance companies host ghost networks, they are selling health coverage under false pretenses, because the mental health providers advertised in their plan directories aren't picking up the phone or taking new patients. In any other business, if a product or service doesn't meet expectations, consumers can ask for a refund. . ..
>
> It's not hard to imagine how many Americans simply give up and go on struggling without the help they need. . ..
>
> If a student were writing an essay and 80 percent of their citations were incorrect or made up, they'd receive an "F." If a business gave the SEC false or incorrect information, it would face extremely severe

[39] *Id.* (Statement of Robert L. Trestman, PhD, MD at 2–3).

> consequences. So in my view insurance companies should face strict consequences if their products don't live up to the billing.[40]

40. When asked whether plans made their directories "inaccurate by design," testifying witness Mary Giliberti, the Chief Public Policy Officer of Mental Health America, responded:

> MS. GILIBERTI: [A]bout 60 percent of the plans [being discussed] don't have out of network coverage, so if you get really frustrated and you pay on your own then they're not paying anything.
>
> SENATOR WARREN: So the more the Medicare Advantage plan can frustrate you . . . the more you'll just go somewhere else. And that means it's not money out of their pockets. . . . So, look, what we are really saying here is that it is in the financial interests of these . . . plans to discourage beneficiaries from accessing care . . . . Because here's the key that underlines this. Whatever insurers don't spend on care as a result of tactics like outdated provider directories or overly restrictive networks or inaccurate information, whatever they don't spend on care, they get to keep.[41]

B. The New York Attorney General's Study

41. In December 2023, the New York State Office of the Attorney General ("OAG") issued its own report regarding Defendant's ghost network.[42]

42. The OAG conducted a secret shopper survey of Healthfirst. The OAG tried to reach 20 mental health providers in New York City listed by Healthfirst as in-network, but found that only seven actually were. And of those, only one would offer any type of appointment, with no

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[40] *Wyden Calls for Action to Get Rid of Ghost Networks, Releases Secret Shopper Study*, U.S. Senate Fin. Comm., Chairman Ron Wyden (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/Wyden%20Ghost%20Networks%20Hearing%20Remarks%205.3.23.pdf.

[41] Senate Hearings on Mental Health Care (Testimony of Senator Elizabeth Warren).

[42] Office of the New York State Attorney General Letitia James, *Inaccurate and Inadequate: Health Plans' Mental Health Provider Network Directories* (2023), https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf (hereinafter "NYS OAG Report").

provider offering an in-person appointment. The OAG calculated the Healthfirst ghost listing percentage at 95 percent.[43]

43. The OAG's findings were even worse when looking specifically for providers who treat children. Of the seven children's mental health providers that the OAG attempted to contact, only four were in-network, and none actually treat children despite being listed in the Healthfirst directory as doing so. The OAG's search found no in-network providers offering appointments for children.[44]

44. Of all the purportedly in-network providers that the OAG attempted to contact, 40% were impossible to reach due to incorrect or non-working phone numbers provided by Healthfirst or unreturned calls. Another 15% were not actually practicing at the office for which Healthfirst had provided contact information. A further 35% of providers were not actually in-network, did not actually provide the services that were listed in the directory, or required a referral from within their practice before they would take on a new patient.[45]

C. Plaintiffs' Counsel's "Secret Shopper" Studies

45. In January 2026, Plaintiffs' counsel conducted secret shopper studies to replicate Plaintiffs' experiences trying to locate a provider. Counsel utilized experienced and qualified researchers to conduct these studies using a methodology developed by a prominent health policy academic.

46. Using Defendant's online provider directory, the research consultants generated a list of supposedly in-network providers accepting new patients within a 20-mile radius of the zip

[43] NYS OAG Report at 28.

[44] *Id.*

[45] *Id.*

code where each Plaintiff resides. Plaintiffs' counsel used the same criteria Plaintiffs used when searching for behavioral health care: whether a psychologist, an occupational therapist, or a psychiatrist.

47. The consultant then called a randomized sample of the listed providers. If a call was not answered, the consultant would make a second and third attempt over multiple days and would leave a voicemail asking for a return call after each attempt. For every completed call, researchers recorded the provider's response: whether they were indeed the type of provider listed in the directory; whether they accepted Defendant's plan; whether they were accepting new patients; and how long the wait was for an appointment.

48. For the study replicating Plaintiff Joe Greene's experience, the provider search yielded 478 providers. Overall, less than 28% of the listed providers were in-network, could be reached, provided the listed services, and were willing to schedule an initial appointment.

49. It was not possible to make an appointment with 39 of the total 50 directory listings called. Fully 11 providers were unreachable—they never returned the calls, or the phone number was incorrect or out of service. Of the remaining providers that were reachable, 17 did not accept the insurance plan, were not accepting new patients, did not provide the necessary services, had no appointments available within one month, and/or were not practicing at the listed location. The research consultants were able to reach an additional 5 providers but were unable to confirm those providers' network status and availability by phone. A further 4 provider listings were duplicates of others already included in the sample.

50. This is a 72% ghost rate for Defendant's network.

51. The researchers repeated the study steps to replicate Plaintiff Pamela Mazza's search for a mental health provider. This search yielded 1,587 providers. Overall, only 20% of the

listed providers were in-network, could be reached, provided the listed services, and were willing to schedule an initial appointment.

52. It was not possible to make an appointment with 45 of the 50 directory listings called. Fully 11 providers were unreachable—they never returned the calls or the phone number was incorrect or out of service. Of the remaining providers that were reachable, 9 did not accept the insurance plan, were not accepting new patients, did not provide the necessary services, had no appointments available within one month, and/or were not practicing at the listed location. The research consultants were able to reach an additional 3 providers but were unable to confirm those providers' network status and availability by phone. A further 22 provider listings were duplicates of others already included in the sample.

53. That is an 80% ghost rate for Defendant's network.

54. The researchers repeated the study steps to replicate Plaintiff Deborah Schutt's search for a mental health provider. This search yielded 2,560 providers.

55. Overall, only 22% of the listed providers were in-network, could be reached, provided the listed services, and were willing to schedule an initial appointment.

56. It was not possible to make an appointment with 34 of the 50 directory listings called. Fully 19 providers were unreachable—they never returned the calls or the phone number was incorrect or out of service. Of the remaining providers that were reachable, 15 did not accept the insurance plan, were not accepting new patients, did not provide the necessary services, had no appointments available within one month, and/or were not practicing at the listed location.

57. That is a 77% ghost rate for Defendant's network.

FACTUAL ALLEGATIONS

VI. Plaintiffs' Needs for Mental Health Care

A. Joseph Greene

58. Plaintiff Joseph Greene is a resident of Bronx County, New York.

59. Mr. Greene has been enrolled in health insurance through Healthfirst since January 2023. From January 1, 2023 to March 31 2024, he was enrolled in the Healthfirst Gold Leaf Premier plan (the "Gold Leaf" plan). From April 1, 2024 through August 31, 2025, he was enrolled in the Healthfirst Essential Plan 200-250. He has been enrolled in the Healthfirst Essential Plan 1 since September 1, 2025.

60. Mr. Greene enrolled in the Healthfirst plans through the New York's marketplace, NY State of Health. When Mr. Greene renewed his health insurance through the marketplace in 2024 and 2025, he was automatically switched to the Essential Plan 200-250 and then to the Essential Plan 1, respectively.

61. Throughout his time as an enrollee in a Healthfirst plan, Mr. Greene had an individual contract directly between himself and Healthfirst. Each of those contracts stated: "This is Your individual Contract for the Essential Plan coverage issued by Healthfirst PHSP, Inc." Each of those contracts stated: "You have been enrolled in an Essential Plan. We will provide the benefits described in this Contract to You," including medically necessary mental health services provided by a "Participating Provider." The contracts defined "You" and "Your" as "The Subscriber"—*i.e.*, Mr. Greene and his dependents.

62. Each of Mr. Greene's contracts with Healthfirst included the following provisions:

a) Healthfirst agrees to provide coverage for "outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health

conditions." This coverage includes "services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counsel; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof."

b) The contract directs members to the Healthfirst provider directory (which is published both online and in hard copy) to locate an in-network provider and guarantees that "The Provider directory will give You the following information about Our Participating Providers: Name, address, and telephone number; Specialty; Board certification (if applicable); Languages spoken; Whether the Participating Provider is accepting new patients."

c) When a member "request[s] an appointment for outpatient mental health care or outpatient substance use services, a Participating Provider must offer You an appointment within . . . Ten (10) business days for an initial appointment."

d) Healthfirst agrees to have "designated staff to assist You in finding a Participating Provider who can treat Your mental health condition or substance use disorder. You may contact Our designated staff by calling the number available on Our website."

e) When a member is unable to find an in-network provider and contacts Healthfirst by phone to submit an Access Complaint, Healthfirst is required within three days to locate a provider who is available within a reasonable distance and time to treat the member's mental health condition. If Healthfirst is unable to locate a provider within three days, it must notify the member of their right to receive a referral to an

out-of-network provider. Services provided by this out-of-network provider must be covered by Healthfirst "as if they were provided by a Participating Provider."

f) Healthfirst must comply with "New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law."

63. Mr. Greene suffers from complex PTSD. Accordingly, when Mr. Greene searched for a health insurance provider at the end of 2022, he sought a plan that offered robust mental health coverage.

64. Mr. Greene learned about Healthfirst's mental health coverage through a television commercial that touted Healthfirst's network of mental health providers. Mr. Greene investigated further on Healthfirst's website and the NY State of Health website. Both advertised that Healthfirst offered a robust network of mental health care providers.

65. When deciding to enroll himself and his family in coverage through Healthfirst for 2023, Mr. Greene specifically relied on Healthfirst's representations that it adequately covered in-network mental health care. Mr. Greene, who had no way to test the accuracy of Healthfirst's provider directory until after he enrolled, was led to believe that he would be able to find an in-network psychiatrist and therapist within 30 minutes of his home who had availability to see a new patient within four to six weeks.

66. Mr. Greene's former provider retired in 2022, so Mr. Greene began searching for a psychiatrist in the Healthfirst provider directory immediately after enrolling in coverage through Healthfirst in January 2023.

67. Mr. Greene, who relies on medication that must be prescribed by a psychiatrist or nurse practitioner, urgently needed to find a new provider to be able to continue receiving his

medication. But when he began calling providers from the Healthfirst directory, he was unable to find a provider who was in-network and accepting new patients.

68. First, Mr. Greene attempted to search Healthfirst's provider directory by filtering for practitioners who treated anxiety and depression. When Mr. Greene was unable to find a provider this way, he widened his search to all psychiatrists and therapists.

69. Similarly, Mr. Greene began his search by filtering for a provider within five miles of his residence. When that failed, he increased his search radius to 25 miles from his home.

70. Mr. Greene called approximately 35 providers listed in Healthfirst's directory. When providers did respond to his calls, some said that they were not in Healthfirst's network and did not know why they were listed in the directory. The remainder told Mr. Greene that they did not have availability to take new patients. At best, he was offered an appointment six to eight months in the future, which would force him to go without his medication in the meantime. Mr. Greene did not understand why providers were listed in Healthfirst's directory if they did not have availability to see new patients until six months later.

71. After being unable to locate an available provider through the directory, Mr. Greene called Healthfirst to submit an Access Complaint, informing them of his difficulty locating an available in-network provider. Healthfirst initially referred Mr. Greene back to the directory as the resource for locating available, in-network care. When Mr. Greene told Healthfirst that he could not find a provider in the directory who was available to book an appointment, Healthfirst told him that its obligation was merely to supply a list of providers who *could* prescribe his medication, not necessarily providers who *would* prescribe it. This response devastated Mr. Greene, who at the time panicked that he would experience severe psychological symptoms without his medication. Healthfirst did not offer to find Mr. Greene an available provider within three days, as required by

Mr. Greene's contract. He received no follow-up communication from Healthfirst regarding his inability to find care.

72. Mr. Greene then sought advice from his primary care provider, who suggested that he reach out to providers within the Montefiore system, which is in-network with Healthfirst. Mr. Greene contacted more than ten Montefiore providers. The providers who responded told him they had no availability for six to ten months.

73. In November 2023, unable to go without care any longer, Mr. Greene began seeing an out-of-network psychiatrist. Because his Healthfirst plan does not provide any coverage for out-of-network care, Mr. Greene has incurred significant costs for this care. Over the past three years, Mr. Greene has spent $175 per month on monthly sessions with his psychiatrist. If this same care were covered by Healthfirst, the monthly cost would be $20.

74. Because prescribing and adjusting psychiatric medication requires an ongoing relationship with a patient, Mr. Greene is unable to switch from his out-of-network psychiatrist. Continuing with the psychiatrist who knows his case is crucial for Mr. Greene's health and wellbeing.

75. Mr. Greene re-enrolled in a Healthfirst plan in 2024 and 2025 for reasons including that he and his dependents developed critical relationships with in-network, non-mental-health-care providers who understood their medical needs. That was the intended, or at least foreseeable, effect of Healthfirst's bait-and-switch scheme: lure people into its health insurance plan with false promises of mental health benefits, and by the time the next enrollment period comes around, they will be trapped by their (or their family members') dependence on their existing medical providers and the difficulty of switching plans.

76. Mr. Greene relied on Defendant's representations in its marketing materials, website, provider directory, and plan documents when deciding to enroll in Defendant's plan and, once enrolled, to understand his benefits.

77. When deciding to enroll in coverage through Healthfirst, Mr. Greene relied on implicit and explicit representations by Defendant that the provider directory was robust and accurate, especially with respect to mental health providers.

78. Over the same time period during which Defendant failed to supply in-network mental health providers within a reasonable distance of Mr. Greene's residence, Mr. Greene identified and received treatment from in-network providers within a reasonable distance for primary care, neurology, gastroenterology, urology, rheumatology, cardiology, and pulmonology.

79. On information and belief, over the same period, other members of the class were able to identify in-network providers within a reasonable distance for analogous medical and surgical services, including physical therapy, orthopedics, pain management, psychiatry, neurology, cardiology, podiatry, dermatology, rheumatology, gastroenterology, oncology, immunology, anesthesiology, and internal medicine, and Defendant approved claims for these services.

B. Pamela Mazza

80. Pamela Mazza is a resident of Bronx County, New York.

81. Ms. Mazza was enrolled in the Healthfirst Medicaid Managed Care plan from approximately January 1, 2024 until August 31, 2025. She has been enrolled in the Healthfirst Essential Plan 2 since September 2025.

82. When deciding to enroll herself in coverage through Healthfirst, Ms. Mazza specifically relied on Healthfirst's representations that its plan provided robust and adequate coverage for in-network mental health care.

83. Ms. Mazza began looking for a therapist using the Healthfirst directory in June 2025. She searched for providers that specialized in autism and ADHD. However, Ms. Mazza was not able to identify any providers through the directory who specialized in treating autism, and the directory listed very few providers who were qualified to treat ADHD. Because the directory generated so few results for her initial search, Ms. Mazza expanded her search to include providers trained in trauma.

84. Ms. Mazza called approximately 20 providers in an attempt to locate an in-network therapist who could help her. The providers Ms. Mazza was able to reach told her they did not accept Ms. Mazza's Healthfirst insurance or were not taking new patients. Worn down by the process of calling so many providers unsuccessfully, Ms. Mazza gave up on finding a therapist, despite her continued need for care.

85. Ms. Mazza began searching for a psychiatrist to treat her ADHD and depression complicated by autism around February 2025. After attempting to identify available qualified providers through the Healthfirst website, she called Healthfirst to request assistance locating a provider. Healthfirst provider her with a list of supposedly available, in-network providers. However, of the five providers that Ms. Mazza attempted to contact from that list, two of the phone numbers were incorrect and the remaining three never returned her calls. At that point, Ms. Mazza abandoned her search.

86. With the assistance of a social worker through the long COVID clinic at Mount Sinai Hospital, Ms. Mazza renewed her search for an in-network psychiatrist in fall of 2025. After

four months of searching, the social worker has not been able to locate an in-network provider for Ms. Mazza.

87. In January 2026, Ms. Mazza called Healthfirst to discuss her difficulty finding a provider. After the representative identified a clinic with four providers that appeared able to provide the care that Ms. Mazza needs, she requested that they send her the contact information for the clinic so that she could schedule an appointment. Instead, Healthfirst sent her a PDF of the full provider directory. Ms. Mazza combed through pages of the directory to try to identify the clinic that the representative had identified. Eventually, she found what she believed to be the correct clinic and called to schedule an appointment. After a lengthy hold, she was not able to reach anyone.

88. Ms. Mazza began looking for a doctor of psychology to perform a neuropsychological evaluation to assess her for autism and ADHD in March 2025. At the time of Ms. Mazza's search, the Healthfirst directory listed only three doctors of psychology who were available to perform the exam. Ms. Mazza called all three providers: one did not answer or return her call, one was not accepting Healthfirst insurance, and one only provided neuropsychological examinations related to memory loss.

89. Ms. Mazza petitioned Healthfirst for out-of-network coverage under a single-case agreement in April 2025 so she could see an out-of-network provider for the exam given that no in-network providers were available. Healthfirst denied the request on May 19, 2025. After contacting her state representative's office for assistance, Ms. Mazza appealed and received an authorization for out-of-network care on June 6, 2025. However, Healthfirst then delayed reaching the necessary single-case agreement with Ms. Mazza's selected provider, such that the out-of-network authorization that Ms. Mazza had received lapsed in August 2025.

90. When the authorization lapsed, Ms. Mazza contacted Healthfirst to request a new authorization. Healthfirst claimed that they had no record of the authorization, so Ms. Mazza was forced to start the entire process for obtaining an out-of-network authorization again. After another multi-month process, Ms. Mazza again contacted her state representative, who helped her report the situation to the New York Department of Health. Healthfirst then re-approved her authorization to receive out-of-network care with a single-case agreement. Healthfirst did not finalize the single-case agreement with Ms. Mazza's provider until November 2025, just two days before Ms. Mazza's scheduled exam and over eight months after Ms. Mazza began searching for an in-network provider.

C. Deborah Schutt

91. Deborah Schutt is a resident of New York County, New York.

92. Ms. Schutt has been enrolled in health insurance through Healthfirst since October 2022. From October 2022 until December 31, 2023, she was enrolled in the Healthfirst Gold Leaf Premier plan. From January 1, 2024 until December 31, 2025 she was enrolled in the Silver Leaf Premier Plus plan (the "Silver Leaf" plan). She has been enrolled in the Healthfirst Bronze Leaf Premier plan since January 1, 2026.

93. Ms. Schutt enrolled in each of these plans through NY State of Health.

94. When deciding to enroll in coverage through Healthfirst, Ms. Schutt relied on Healthfirst's representations that each plan included coverage for mental health care and access to an extensive network of providers. Ms. Schutt used the Healthfirst directory before enrolling in the Gold Leaf Premier Plan in October 2022 to check that her current healthcare providers were in-network. When making the decision to switch to the Silver Leaf plan during the open enrollment

period for selecting coverage for 2024, she checked that her providers were still in-network for that plan.

95. Ms. Schutt started to experience mental health struggles in the summer of 2024 while enrolled in the Silver Leaf plan. She attempted to find care using the provider directory through the Healthfirst app and website. Ms. Schutt was open to any mental health provider type so she simply typed the word "therapy" into the directory's search bar and began calling providers from the search results that were located in her neighborhood.

96. Ms. Schutt called approximately ten offices—many with multiple providers listed at the location—that she found through the directory on the Healthfirst app. The providers she was able to reach told her that they were not in-network with Healthfirst, that they were not accepting new patients, or that they had a months-long waitlist for new patient appointments.

97. Unable to find timely care through the Healthfirst directory, Ms. Schutt turned to searching through Zocdoc, a third-party website that allows users to search for and book healthcare appointments within a chosen insurance network. She was able to find and book appointments with an in-network psychiatric nurse practitioner and therapist through this search in mid-September. However, she did not find their treatment to be effective, in part because of significant medication-related side effects that she experienced.

98. Ms. Schutt's mental health symptoms worsened during the fall of 2024 and she began to experience physical manifestations including panic attacks. After these symptoms prompted her to seek urgent care, she spoke with her primary care provider about her struggle locating an in-network mental health provider. Her primary care provider referred her to an in-network provider, but this provider had a waiting list that was several months long.

99. Desperate to find effective care, Ms. Schutt returned to searching with Zocdoc and was able to find an out-of-network provider that could treat her mental health issues. Ms. Schutt initially saw the out-of-network provider weekly but was able to reduce the frequency of her visits starting in August 2025. She now sees this provider approximately once a month. The provider charges Ms. Schutt $400 per session.

100. During the same period that Ms. Schutt struggled to find in-network mental health care using Defendant's directory, Ms. Schutt successfully found physical health care providers, including a cardiovascular specialist and gastroenterologist, through the Healthfirst directory.

VII. Defendant's Ghost Network

A. Defendant's Plans and Mental Health Coverage

101. New York State contracts with Healthfirst to provide health insurance benefits, including mental and behavioral health benefits, to people eligible to enroll in Qualified Health Plans, Essential Plans, and the Medicaid Managed Care Plan through the NY State of Health marketplace.

102. For the Essential Plans, that contract provides the following:

a) Healthfirst will provide insurance "services to Enrollees pursuant to this Agreement," with the "Enrollee" defined as "an Eligible Individual enrolled in an Essential Plan" offered by the insurer. The contract requires Healthfirst to provide a "member handbook" to enrollees "to inform them of how to access covered Health Care Services and [that] explains their rights and responsibilities as an Enrollee of the Contractor [*i.e.*, Healthfirst]."

b) Healthfirst is required to be "duly licensed pursuant to NY State Insurance Law" and/or certified "to provide health insurance in New York." Healthfirst is further required to "comply with State processes, procedures, and requirements established

for the certification of individual health plans as Essential Plans." The contract also requires Healthfirst to comply with all applicable federal law and regulations.

c) Healthfirst must "establish and maintain a network of Participating Providers" and comply with federal law and guidance governing "network adequacy standards." The provider network "must contain all the provider types necessary to furnish the Essential Plan(s), including but not limited to hospitals, physicians (primary care and specialists), mental health and substance abuse providers," and others. The insurer's "behavioral health network . . . must include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities."

d) In establishing the provider network, Healthfirst "must consider" "anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees." Under the contract, "[t]o be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population and to assure that Enrollees have access to all services without undue delay. This includes geographic accessibility (i.e. meeting time / distance standards) and accessibility for people with disabilities." The insurer is required to "undertake its best efforts" to ensure that providers—including behavioral and mental health providers—were available within 30 minutes of public transportation (if within a metropolitan area) or within 30 minutes or 30 miles by public transportation or by car (in non-metropolitan areas).

e) In a section entitled "Enrollee Rights and Notification," with a subsection entitled "Provider Directories," Healthfirst is required to "maintain and update, and make publicly available, a listing by specialty of all Participating Providers, including facilities (the 'Provider Directory'). Such Provider Directory shall include names, office addresses, telephone numbers, specialty, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of Participating Providers. The Provider Directory should also identify providers that are considered Primary Care Physicians and providers that are not accepting new patients. Consistent with the 2014 Out-of-Network Law, electronic versions of such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation." The contract further requires the insurer to "implement a system to periodically verify the accuracy of its reported Essential Plan provider network(s), to validate participation by individual providers and assure that individual providers are aware of their participation in the Essential Plan network(s)." And the contract requires Healthfirst to "notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request."

103. On information and belief, New York State's contracts with Healthfirst to offer Qualified Health Plans and the Medicaid Managed Care Plan all contain the provisions quoted above.

104. Separately, Healthfirst contracts directly with individual enrollees in its health insurance plans. On information and belief, across the Qualified Health Plans, Essential Plans, and Medicaid Managed Care plan, these contracts all contain the provisions quoted above from Mr. Greene's individual health insurance plan.

Gold Leaf Premier Plan

105. Healthfirst's Gold Leaf Premier plan is a Qualified Health Plan offered on the NY State of Health marketplace. In New York, Gold-tier marketplace plans feature higher monthly premiums but lower deductibles and copays, making them suitable for consumers who frequently require medical care.[46]

106. Enrollees in the Gold Leaf Premier plan pay a monthly premium, which income-eligible enrollees can offset using premium tax credits.

107. While enrolled in the Gold Leaf Premier plan, Mr. Greene paid a monthly premium of $957.39 in 2023 and $1,302.49 in 2024 after applicable premium tax credits for coverage for himself, his wife, and their two children.

108. Since at least 2023, outpatient mental health services have been subject to a $20 copay when provided by an in-network provider. The Gold Leaf Premier plan offers no coverage for mental health services from out-of-network providers.

109. According to the Plan's Summary of Benefits and Coverage, preauthorization is required for "Select Services" within the mental health category before coverage is available.

110. For in-network care, out-of-pocket costs are capped at $12,500 for a family for the year. There is no cap for out-of-network spending.

[46] VistaHealth, Qualified Health Plans: NY State of Health, https://www.nyhealthinsurer.com/qualified-health-plans/, last accessed Oct. 21, 2025.

Silver Leaf Premier Plus Plan

111. Healthfirst's Silver Leaf Premier Plus plan is a Qualified Health Plan offered on the NY State of Health marketplace.

112. Enrollees in the Silver Leaf Premier Plus plan pay a monthly premium, which income-eligible enrollees can offset with premium tax credits.

113. While enrolled in the Silver Leaf Premier Plus plan, Plaintiff Deborah Schutt paid a premium of $864.61 per month in 2024 and $974.64 per month in 2025. She did not receive premium tax credits in either 2024 or 2025 to offset her premium.

114. In 2024, the individual deductible for the Silver Leaf Premier Plus plan was $2,000. After the deductible was met, in-network outpatient mental or behavioral health services were subject to a $30 copay. The maximum individual out-of-pocket cost for in-network care was $9,100, and there was no out-of-pocket maximum for out-of-network care. The plan did not cover out-of-network mental or behavioral health services.

Essential 200-250 Plan

115. Healthfirst's Essential 200-250 Plan is available to New Yorkers with a household income between 200% and 250% of the federal poverty level.

116. Enrollees in the Essential 200-250 Plan pay no premium, but the State of New York subsidizes their enrollment by paying a capitated rate to Healthfirst for each New Yorker that enrolls in the Plan.[47]

[47] NY State of Health, Invitation and Requirements for Insurer Certification and Recertification for Participation in 2026, at 36, https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Plan%20Invitation%202026%20Revised%2005-08-25.pdf ("EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP.").

117. Outpatient mental health services are subject to a $15 copay when provided by an in-network provider. The Essential 200-250 Plan offers no coverage for mental health services from out-of-network providers.

118. For in-network care, out-of-pocket costs are capped at $2,000 for the year. There is no cap for out-of-network spending.

119. According to the Plan's Summary of Benefits and Coverage, preauthorization is required for "Select Services" within the mental health category before coverage is available.

Essential Plan 1

120. Healthfirst's Essential Plan 1 is available to New Yorkers with a household income between 150% and 200% of the federal poverty level.

121. The Essential Plan 1 has no premium and no deductible. As with the Essential 200-250 Plan, Healthfirst receives a capitated rate payment from New York State for each enrollee.

122. The plan requires a $15 copay for in-network outpatient mental health services and provides no coverage for out-of-network outpatient mental health services.

123. According to the Plan's Summary of Benefits and Coverage, preauthorization is required for "Select Services" within the mental health category before coverage is available.

124. For in-network care, out-of-pocket costs are capped at $360 for the year. There is no cap for out-of-network spending.

Medicaid Managed Care Plan

125. Healthfirst's Medicaid Managed Care plan is available to Medicaid-eligible New Yorkers.

126. The Medicaid Managed Care plan has no premium and no deductible. As with the Essential Plans, Healthfirst receives a capitated rate payment from New York State for each enrollee.

127. The Medicaid Managed Care plan offers no coverage for mental health services from out-of-network providers.

B. Defendant's Provider Directory

128. Before Plaintiffs' enrollment in Defendant's health insurance (when Plaintiffs were deciding whether to enroll in this insurance) and throughout Plaintiffs' enrollment in Defendant's health insurance, Defendant has published an inaccurate directory of mental health providers who are supposedly in-network with Defendant, available to see new patients, and qualified to provide specified mental health services. Defendant's provider directory is the definitive resource to identify which providers are in Defendant's network and are thereby covered at the plan's in-network rate. This directory is publicly available to members and non-members of the Healthfirst's plans.[48]

129. The Healthfirst Essential Plan Handbook directs members to HFDocFinder.org—which redirects to the Healthfirst provider directory—to "find participating doctors." The Handbook also notes that the Essential Plans do not cover out-of-network care, so members should "make sure your provider is in the Healthfirst network" by visiting HFDocFinder.org.

130. The Healthfirst Silver Leaf Plan Handbook directs members to visit HFDocFinder.org—which redirects to the Healthfirst provider directory—when members need to find "a new doctor." In the Silver Leaf Plan Summary of Benefits, members are told to "See www.healthfirst.org or call 1-888-250-2220 for a list of network providers."

131. The Healthfirst Medicaid Managed Care Plan Handbook instructs members to "Check our Provider Directory or call Member Services for help finding a provider." It explains that members may access the provider directory by "calling 1-866-463-6743 or visit[ing] our

[48] Healthfirst, Find a Doctor, https://healthfirst.org/find-a-doctor, last accessed Oct. 28, 2025.

website at HFDocFinder.org." The Medicaid Managed Care Insurance Card directs members to "visit MyHFNY.org to find a doctor."

132. Defendant's directory can be sorted and searched based on the following criteria: gender, age-treated, accepting new patients, language spoken, location, office hours, hospital affiliation, focus area, virtual visits, and more.

133. Defendant's provider directory affirmatively misrepresents to current and prospective members that the mental health providers listed are in fact in-network and will be accessible and available to provide care. Instead, the vast majority of providers listed in the directory do not exist or are not in-network, not available, not reachable, not qualified to provide the services listed for them, or not actually practicing at the listed location. Defendant's misrepresentations regarding the breadth of its network occurred continuously before and throughout Plaintiffs' enrollment in Defendant's health insurance.

134. Moreover, Defendant's provider directory is replete with all kinds of other inaccuracies, including incorrect addresses and phone numbers, as well as repeated entries of the same provider. These inaccuracies may appear at first glance to be a minor oversight, but such errors are far from trivial for a person who needs mental health care for themself or a loved one. The inclusion of incorrect listings artificially inflates the perceived size and adequacy of Defendant's network and forces members to invest more time and energy trying to find a mental health provider—only to be repeatedly led to a dead end.

135. These inaccuracies make it appear as if Defendant contracts with vastly more mental health providers than it does. Accordingly, Defendant's provider directory, and representations about its comprehensive mental health coverage, are inaccurate, deceptive, and

misleading. They have been so before and throughout Plaintiffs' enrollment in Defendant's health insurance.

VIII. Defendant's Deceptive and Misleading Activity

A. Defendant's Misrepresentations and Omissions

136. For ease of reading, the misrepresentations and omissions outlined in this complaint are generally phrased in the present tense. However, all of these misrepresentations and omissions are not only currently being made, they were also made before and throughout Plaintiff's enrollment in Defendant's health insurance.

137. Defendant holds itself out to consumers—through the provider directory and marketing materials—as having a robust network of providers to meet members' mental health care needs. These representations are deceptive, as the directory misrepresents the breadth of the network and the ease of utilizing the benefits available under the insurance plan.

138. In addition to publishing and maintaining an inaccurate provider directory, Defendant provides consumers with deceptive and materially misleading marketing and program materials about the benefits offered under its plan. These materials promise mental health benefits and a robust network of providers.

139. Plaintiffs decided to enroll in their insurance plans based on representations that they would have access to a robust network of both physical and mental health providers adequate to meet their healthcare needs.

140. When deciding to enroll in coverage, Plaintiffs relied on implicit and explicit representations that the provider network was robust and accurately reflected in the directory.

141. On its "About Us" page, Healthfirst boasts a network of more than 40,000 providers. This representation is grossly misleading because an estimated 95 percent of those listings are "ghosts." Defendant's network is far smaller than advertised.

142. On its Frequently Asked Questions page, Healthfirst claims to have "a large network that includes thousands of doctors and specialists." In answering the question "Why should I choose Healthfirst?" Defendant states that "With access to thousands of doctors and specialists, ***you're sure to find the service you need nearby***."

143. Healthfirst regularly emails prospective members to advertise its plans. In one recent email with the subject line "Explore our large provider network," Healthfirst states that "As a Healthfirst member, you'll have access to a large network of primary care providers (PCPs) and specialists—with low or no copays. With so many doctors to choose from, ***it's easy to get the care you need from an experienced provider***." The email includes a link to the provider directory with the text "Explore our network today."

144. Even the Member Handbooks include statements promising access to "a ***large network*** of doctors and specialists."

145. These statements are misrepresentations and misleading because consumers like Plaintiffs spend a great deal of time searching for in-network providers of mental health care, often to no avail. Consumers often have to seek help out of network because Defendant's network lacks adequate providers.

146. On a page discussing Healthfirst's "Plan Benefits and Features," Healthfirst claims to have a "large network of doctors" and "Member services who will help you get the care and support you need."

147. This statement is inaccurate and misleading because Defendant does not have a large provider network on which consumers can rely. Its directory is intentionally and grossly inaccurate, and consumers are often left struggling and wasting time searching for treatment long after they start to seek out a mental health professional.

148. Defendant misleads consumers by making them believe that they will have access to a sufficiently broad network of providers to meet their healthcare needs and make use of the coverage provided by Defendant, when, in reality, Defendant's directories are inaccurate and its network is sparse.

149. When Mr. Greene contacted Defendant directly by phone, he was told by Healthfirst representatives that he could and should use the online provider directory to locate available, in-network providers. Defendant also told Mr. Greene that it had no responsibility to ensure that he was able to locate timely care so long as it directed him to the list of providers.

150. Consumers rely on an insurer's directory to find providers in their health plan. As stated by the American Medical Association and the Council for Affordable Quality Healthcare:

> Health plans are expected by their members and their contracted practices to display a provider directory to the public that represents an accurate reflection of their networks. It is the most public-facing data that health plans provide, and patients are dependent on accurate directories to access care.[49]

151. On its website, Healthfirst repeatedly directs consumers to its provider directory to find in-network care. On its FAQ page, it states that members should "visit HFDocFinder to find an in-network Healthfirst provider."[50] Defendant's repeated focus on the importance of using an in-network provider, and repeated direction of members to use the provider directory to find an in-network provider, implies that members can rely on the directory to accurately reflect the pool of available, in-network providers.

152. In truth, its directory reflects a 95% ghost rate.

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[49] Improving Health Plan Provider Directories at 7.

[50] The HFDocFinder text links to the provider directory, available at healthfirst.org/find-a-doctor.

153. Any argument by Defendant that the members themselves should have verified that the providers were in fact in-network does not absolve Defendant of its obligation to accurately represent the mental health providers available in its network.

154. Any boilerplate disclaimers Defendant might provide would be woefully insufficient. Put another way, no reasonable consumer viewing a boilerplate disclaimer would understand that up to 95% of mental health providers listed in Defendant's directory are not available to treat members of Defendant's plan. Indeed, there is no disclaimer broad enough to absolve that level of deception.

155. In the Summary of Benefits and Coverage for each of its plans, Defendant represents that the plan provides Minimum Essential Coverage and meets the Minimum Value Standards for coverage required by the Affordable Care Act.

156. Separately and together, Defendant's representations mislead consumers to believe that members will have access to the robust network of providers reflected in its provider directory, that the network is broad enough to allow them to easily utilize their comprehensive coverage with Defendant, and that they only need to look to and rely on the provider network to find necessary mental health care. In reality, Defendant's failure to maintain an accurate directory makes it nearly impossible to obtain in-network mental health care.

157. The incorporation of the inaccurate directory into the plans' marketing materials through references to providers, services, and network on Defendant's public website constituted a knowing false statement and representation of fact in connection with the marketing and sale of the plan.

158. In addition to the affirmative misrepresentations made by Defendant about the breadth of its provider network and comprehensiveness of Defendant's mental health care

coverage, Defendant also makes material omissions, including but not limited to its failure to disclose:

a) the inadequacy of Defendant's network to meet members' care needs;

b) the extent of provider directory inaccuracies;

c) that the vast majority of in-network mental health providers are not accessible;

d) the likelihood that members will be unable to find an in-network mental health provider through the directory;

e) the likelihood that members will need to delay or forgo coverage, or resort to using an out-of-network provider; and

f) the likelihood that members will be unable to use the coverage that their plan provides for in-network mental health care.

159. There is complete information asymmetry between Defendant and consumers: Defendant has an obligation under the law to access all the relevant information, including its own contracts with in-network providers, to determine whether providers are accurately listed, and to make regular updates to ensure accuracy. On the other hand, members only become aware of the extent of the directory inaccuracies after enrolling and expending significant time and energy through trial and error, hours of calls, and extensive research. The information is not readily available to Plaintiffs and other consumers.

B. Defendant's Misrepresentations and Omissions Are Material

160. Plaintiffs relied on Defendant's provider directory and representations regarding its provider network when choosing their health plan. Consumers in general regularly rely on a health plan's provider directory to inform their choice of health plan.[51] Over half of consumers in one

[51] *See* Statista, *Most Important Considerations for Americans in Choosing a Plan from a Health Insurance Company as of 2016*, https://www.statista.com/statistics/654828/most-important-

poll identified provider choice as the most important non-financial consideration they make when selecting a health plan.[52] In another survey, participants were willing to pay higher premiums for the ability to continue seeing their existing provider and for a plan with a wider network of providers in their area.[53] And, in a Kaiser Family Foundation survey, 60 percent of non-group health insurance enrollees reported that having a choice of providers was either "very important" or "extremely important" to them.[54]

161. Given the importance of the provider network to prospective members, Defendant's misrepresentations and omissions in its directory would influence the decision of a reasonable consumer—and did influence Plaintiffs' decisions—to enroll in Defendant's health insurance. The provider directory and network information are disseminated by the insurance company, which Plaintiffs and other consumers logically view as the authoritative source of information about its in-network providers, scope of coverage, and other plan policies.

162. As a result of Defendant's misrepresentations and omissions, a reasonable consumer would understandably believe—and Plaintiffs did believe—that each listing in the provider directory represented a health care professional who was in-network with Defendant and accepting new patients. If a reasonable consumer were aware of the extent of the inaccuracies of

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considerations-for-choosing-health-insurance-plan/.

[52] *See* Blumberg et al., *Factors Influencing Health Plan Choice among the Marketplace Target Population on the Eve of the Health Reform*, Urban Inst., 2 (Feb. 6, 2014), https://www.urban.org/sites/default/files/2024-05/hrms_decision_factors.pdf.

[53] Eline M. van den Broek-Altenburg & Adam J. Atherly, *Patient Preferences for Provider Choice: A Discrete Choice Experiment*, Am. J. of Managed Care 26(7) (July 2020), https://www.ajmc.com/view/patient-preferences-for-provider-choice-a-discrete-choice-experiment.

[54] Hamel et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2*, Kaiser Family Foundation (May 2015), https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/ (finding a combined 60 percent of respondents consider choice of providers to be "extremely important" or "very important").

Defendant's directory, the sparse nature of Defendant's provider network, and the consequent difficulties that members face in accessing in-network care, they would not enroll in Defendant's plan. If Plaintiffs had been so aware, they would not have enrolled in Defendant's plans.

163. Accordingly, Defendant's misrepresentations about its mental health provider network and coverage are materially misleading to consumers.

C. Members' Reliance on Defendant's Misrepresentations and Omissions

164. As New York residents seeking coverage from the state health insurance marketplace, Plaintiffs have a choice of health plans. For example, in 2025, the NY State of Health marketplace offered seven Essential Plans—income-gated plans that have no premium and no deductible—from a range of insurers that included Healthfirst, United Healthcare, Emblem, and Anthem BCBS. Each Essential Plan insurer receives a capitated rate from New York for every person who enrolls in coverage, so insurers are incentivized to attract as many new enrollees as possible even if the members themselves do not pay to enroll. The marketplace also offers a number of higher-cost Qualified Health Plans from a range of insurers including Healthfirst.

165. Generally, consumers have the option to enroll in a Qualified Health Plan through the marketplace during the annual open enrollment period at the end of each year. Outside of this limited window, consumers cannot change plans unless they experience a Qualifying Life Event, such as a marriage, birth of a child, or loss of health insurance. As a result, consumers are typically locked into their choice of health plan for a full year, even if they are not able to access care due to misrepresentations about the plan's coverage.

166. When selecting a plan, Plaintiffs relied on Defendant's representations that they would have access to a large network of providers and would have access to low-cost mental health care through the provider network.

167. Mr. Greene selected the Gold Leaf Premier plan specifically because he anticipated that he and his family would require frequent healthcare services—including mental health services—such that paying a higher premium for reduced care costs would be worthwhile.

168. These misrepresentations about the size and breadth of the mental health provider network, the ease of finding mental health treatment by using the provider directory, the freedom to choose any listed in-network provider, the ability to control costs by seeing an in-network provider, and the comprehensive coverage of mental health care would induce a reasonable consumer—and did induce Plaintiffs—to choose coverage through Healthfirst's plans.

D. Defendant Knew That Its Provider Directory Was Inaccurate and That Its Representations Regarding Its Network Were Deceptive

169. At all relevant times (*i.e.*, before and throughout Plaintiffs' enrollment in Defendant's health insurance), Defendant has willfully and knowingly maintained an inaccurate and inflated provider directory to induce consumers to enroll in its health insurance and to hide its non-compliance with network adequacy standards.

170. As discussed above, there are numerous studies and congressional inquiries regarding ghost networks, especially with respect to mental health providers.

171. As one state senator put it, insurance companies have "known about this for a long time and they haven't done anything about it. It's difficult not to assume that this kind of barrier is intentional."[55] Insurance companies have been successfully sued over the issue.[56]

172. The sheer magnitude of the inaccuracies in Defendant's directory—as many as 95 percent of the mental health providers listed—can only be the product of knowing misconduct or

[55] Turban, *supra* n. 36.

[56] *See, e.g.*, *Anthem Resolves Calif. Provider Directory Error Case*, Bloomberg Law (Aug. 17, 2016), https://news.bloomberglaw.com/health-law-and-business/anthem-resolves-calif-provider-directory-error-case.

willful blindness, particularly in light of Defendant's legal obligation to update and maintain the directory.

173. As demonstrated by the secret shopper studies discussed above, Defendant published a false list of mental health providers in New York. Defendant falsely listed non-existent, unavailable, out-of-network, and irrelevant providers (*i.e.*, providers who do not provide the services specified in the directory).

174. Defendant knew that members were having significant problems accessing in-network care. Members, including Plaintiffs, have repeatedly contacted Defendant to report these difficulties.

175. Defendant was incentivized to maintain, generate, and continue to publish an inaccurate directory to attract new enrollees, maintain current enrollees, and profit from enrollees' premiums while not actually providing the coverage that Defendant falsely represented that it provided.

176. On information and belief, at all relevant times (*i.e.*, before and throughout Plaintiffs' enrollment in Defendant's health insurance), Defendant fraudulently and intentionally maintained and published materially false directories of mental health providers in New York to deceive current and prospective enrollees about the extent of their provider network. These intentional and fraudulent misrepresentations were made for the enrichment of Defendant. Even if Defendant could somehow show that such misconduct was unintentional, it was at least knowing, reckless, and negligent.

IX. Defendant Has Been Enriched and Members Have Been Injured by Defendant's Misrepresentations and Omissions

177. Defendant's knowing misrepresentations about the breadth of its provider network confer significant financial benefits on Defendant and, conversely, deprive plan members of the benefit of their bargain.

178. Prospective plan members are more likely to enroll if they see their existing provider listed as in-network or if the list of in-network providers is robust. Masking their inadequate network with an inaccurate provider directory therefore allows Defendant to attract more customers and charge higher premiums—all unjustly boosting Defendant's profits. Indeed, the more customers who enroll in its plan, and the more they pay in premiums, the more Defendant profits. Likewise, every time a member delays or forgoes care after failing to locate an available in-network provider, Defendant evades its obligation to pay for that member's care, reducing costs (and thereby increasing profits).[57] Defendant also reduces costs by not having to expend resources creating and maintaining a robust provider network and accurate provider directory.

179. Plaintiffs and others similarly situated have been grievously injured by Defendant's illegal conduct and the resulting inability to access necessary mental health treatment for themselves and their families.

180. As a result of Defendant's illegal conduct, Plaintiffs and other class members have suffered grievous injury, including facing significant, years-long delays in receiving critical mental health care; having to pay an inflated premium for a worthless product; having to pay exorbitant fees for out-of-network care for themselves and their dependents; and being unable to find appropriate treatment or, alarmingly, any treatment at all.

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[57] *See* Alicia Atwood & Anthony T. Lo Sasso, *The Effect of Narrow Provider Networks on Health Care Use*, J. of Health Econ. (Dec. 2016), https://doi.org/10.1016/j.jhealeco.2016.09.007.

181. Defendant's misrepresentations and omissions are the direct and proximate causes of the harms Plaintiffs have endured. Had Defendant accurately represented its mental health care coverage, Plaintiffs—and countless other consumers—would not have enrolled in coverage with Defendant. By enrolling in one of the other health insurance plans available to them, Plaintiffs would have had access to the care they were promised and saved thousands of dollars in out-of-pocket expenses—not to mention the countless hours and emotional expense they would have been saved.

182. Moreover, Defendant's misrepresentations artificially inflated the market price of its product, causing Plaintiffs to pay more than they otherwise would have for premiums. As a direct and proximate result of Defendant's unfair and deceptive acts and practices, Plaintiffs suffered injury by paying insurance premiums but failing to receive commensurate benefits.

CLASS ACTION ALLEGATIONS

183. This action is brought by Plaintiffs individually and on behalf of a class (the "Class") pursuant to Federal Rule of Civil Procedure 23. The Class includes all individuals who have purchased or enrolled in any of Healthfirst's Qualified Health Plans, Essential Plans, or Medicaid Managed Care Plan in New York at any point from 2019 through the date of class certification.

184. Plaintiffs seek certification of the following Class:

> All persons who are currently, or were previously, enrolled in any of Healthfirst's Qualified Health Plans, Essential Plans, or Medicaid Managed Care Plan at any point from 2019 through the date of class certification.

185. Excluded from the Class are Defendant's officers, directors, employees, co-conspirators, and legal representatives, and any judge, justice, or judicial officer to whom the litigation is assigned.

186. Plaintiffs reserve the right to amend or modify the Class definition.

187. **Numerosity.** The Class consists of thousands of individuals, and is thus so numerous that joinder of all members is impracticable. The exact number and identity of Class members is unknown to Plaintiffs at this time but can be ascertained through appropriate discovery.

188. **Commonality and predominance.** This action is appropriate as a class action because common questions of law and fact affecting the class predominate over those questions affecting only individual members. Those common questions include, but are not limited to, the following:

a) whether Defendant breached its contractual obligations by failing to provide the promised network of providers and/or by failing to comply with the ACA, the No Surprises Act, the MHPAEA, and/or other statutes, regulations, and rules with which Defendant is contractually obligated to comply;

b) whether Defendant's representations and/or omissions with respect to the Gold Leaf Premier, Essential 200-250, Essential 1, Silver Leaf Premier Plus, and Medicaid Managed Care Plans were false or misleading under New York General Business Law ("GBL") §§ 349 and/or 350, New York Insurance Law § 4226(a) or equivalent, and/or common law;

c) whether Defendant's violations of law were willful and knowing;

d) whether Defendant's mental health provider directory was inaccurate and/or inadequate;

e) whether Defendant failed to disclose to members and prospective members that the provider directory was inaccurate and/or inadequate;

f) whether a reasonable consumer would be misled by Defendant's acts and practices;

g) whether Plaintiffs and Class members are entitled to receive specific types of relief such as actual damages, and the methodology for calculating those damages;

h) whether Plaintiffs and Class members conferred a benefit on Defendant through enrollment in the Gold Leaf Premier, Essential 200-250, Essential 1, Silver Leaf Premier Plus, and Medicaid Managed Care Plans, payment of premiums, directing state and federal premium payments to Defendant, and not utilizing in-network providers or otherwise not obtaining mental health care; and

i) whether equity and good conscience require restitution to Plaintiffs and Class members and/or the establishment of a constructive trust, and the amount of such restitution or constructive trust.

189. **Typicality.** The claims asserted by Plaintiffs are typical of the claims of the Class. At all relevant times, Defendant's provider network was inadequate and its directory inaccurate, and all Class members' claims arise out of this common source of misrepresentations and omissions. Plaintiffs, like all Class members, were subject to deceptive and misleading representations and omissions found in Defendant's provider directory and other marketing and plan documents regarding the comprehensiveness of mental health coverage and the provider network. Plaintiffs' interests coincide with, and are not antagonistic to, those of the other Class members, and Plaintiffs and other Class members have been damaged by the same wrongdoing set forth in this Complaint.

190. **Adequacy of representation.** Plaintiffs will fairly and adequately protect the interests of the Class and do not have any interests antagonistic to those of the Class members. Plaintiffs have retained counsel competent and experienced in class actions and health insurance

and consumer protection litigation, who are competent to serve as Class counsel. Plaintiffs and their counsel will fairly and adequately protect the interests of the Class members.

191. **Superiority.** A class action is superior to other available methods for the fair and efficient adjudication of this controversy for at least the following reasons:

a) given the complexity of issues involved in this action, the expense of litigating the claims, and the money at stake for any individual Class member, few, if any, Class members could afford to seek legal redress individually for the wrongs that Defendant has committed against them;

b) the prosecution of thousands of separate actions by individual members would risk inconsistency in adjudication and outcomes that would establish incompatible standards of conduct for Defendant and burden the courts;

c) when Defendant's liability has been adjudicated, claims of all Class members can be determined by the Court;

d) this action will cause an orderly and expeditious administration of the Class claims and foster economies of time, effort, and expense, and ensure uniformity of decisions;

e) without a class action, many Class members would continue to suffer injury while Defendant retains the substantial proceeds of its wrongful conduct; and

f) this action does not present any undue difficulties that would impede its management by the Court as a class action.

192. **Ascertainability.** The identities and addresses of Class members can be readily ascertained from business records maintained by Defendant, and/or self-authentication. The precise number of Class members, and their addresses, can be ascertained from Defendant's

records. Plaintiffs anticipate providing appropriate notice to the Class to be approved by the Court after class certification, or pursuant to court order.

193. Plaintiffs request that the Court afford Class members with notice and the right to opt out of any Class certified in this action.

FIRST CAUSE OF ACTION

Breach of Contract

194. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

195. A contract exists between New York State and Healthfirst to provide health insurance benefits, including mental health benefits, to people eligible to receive health insurance through New York's Essential Plans.

196. A contract exists between New York State and Healthfirst to provide health insurance benefits, including mental health benefits, to New York residents who enroll in a Qualified Health Plan through the NY State of Health marketplace.

197. A contract exists between New York State and Healthfirst to provide health insurance benefits, including mental health benefits, to people eligible to receive health insurance through New York's Medicaid program.

198. Plaintiffs, as New York residents eligible to enroll in coverage through Healthfirst, are intended third-party beneficiaries of these contracts between the state and Defendant.

199. Plan members, *i.e.* Plaintiffs and the Class members, are mentioned throughout the contracts.

200. The contracts between New York State and Healthfirst require Healthfirst to provide these insurance benefits in compliance with federal law.

201. The contracts require Defendant to comply with the Affordable Care Act, Mental Health Parity and Addiction Equity Act, and No Surprises Act, among other federal laws, including sections 2799A–1, 2799A–2, 2799A–3, 2799A-4, 2799A-5, 2799A–7, and 2799A–8 of the Public Health Service Act; sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974; and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986.

202. The Affordable Care Act requires Defendant to maintain an adequate 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."[58] The Affordable Care Act also requires Defendant to "publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients" and to indicate in its provider directory "providers that are not accepting new patients."[59]

203. Defendant has breached the contracts by failing to contract with a sufficient number of mental health providers to allow members to access timely in-network mental health services.

204. The Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26, incorporated into the Affordable Care Act via 45 C.F.R. § 156.115, provides that mental health and substance use disorder benefits must not be provided on less favorable terms than medical and surgical benefits, specifically with respect to annual, aggregate, or lifetime limits on coverage, financial requirements, treatment limitations, and out-of-network coverage.[60] MHPAEA

[58] 45 C.F.R. § 156.230(a)(1)(ii).

[59] 45 C.F.R. § 156.230(b)(1)-(2).

[60] 29 U.S.C. §1185a(a); 42 U.S.C. § 300gg-26(a).

regulations provide that "all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy."[61]

205. Defendant, in administering a marketplace plan that provides both medical and surgical benefits and mental health benefits, included financial requirements and treatment limitations applicable to mental health benefits that were more restrictive than those applied to substantially all medical and surgical benefits covered by the plan. That constitutes a breach of contract.

206. Among the many ways in which Defendant created a disparity in benefits, by falsely representing the scope of available in-network mental health providers, Defendant required Plaintiffs and Class members to disproportionately seek treatment from out- of-network providers and pay higher costs than required of beneficiaries seeking medical and surgical benefits. This financial requirement was more restrictive for mental health benefits than for medical or surgical benefits. Defendant did not apply such treatment limitations to claims for medical and surgical benefits because in-network providers for medical and surgical treatments were more widely available under Defendant's health insurance.

207. Sections 2799A-5 of the Public Health Service Act, 720 of the Employee Retirement Income Security Act of 1974, and 9820 of the Internal Revenue Code of 1986 require health insurers to verify and update their provider directories not less frequently than once every 90 days, remove a provider from the directory when they are unable to verify the directory

[61] Ctrs. for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (2023), https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity; *see also* 29 C.F.R. 2590.712(c)(4).

information for that provider, and update the directory within two days of receiving new information from a provider.

208. Defendant's failure to maintain an accurate and updated directory of in-network providers violates the requirements in the Employee Retirement Income Security Act and Internal Revenue Code and was thus a breach of contract.

209. Defendant has violated the above laws (and, by extension, its contractual obligations to Plaintiffs and the Class) by, among other things, failing to ensure mental health network adequacy, create and maintain an adequate network of providers and a provider directory that includes the names, office addresses, and telephone numbers of providers accepting its insurance, or regularly verify the accuracy of its provider network and validate participation by individual providers.

210. Members of the Class (including Plaintiffs) were damaged in several ways. The following is a non-exhaustive list of the types of damage incurred. First, they did not receive the benefits they were entitled to as members of the plan (most notably, access to the supposedly broad network of available providers). Second, they used out-of-network providers and paid those providers' out-of-network fees for care. Even after the plan reimbursed them the out-of-network allowed amount, these members typically incurred hundreds of dollars in out-of-pocket cost each time they received treatment—a cost far above their expected copay amount. Third, they abandoned their search for care, paying a premium for a service they were supposed to receive and did not, and incurring pain and suffering due to the unsuccessful provider search and their inability to receive treatment.

SECOND CAUSE OF ACTION

Breach of Contract

211. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

212. Defendant and Plaintiffs have a direct contractual relationship. The terms of that direct contractual relationship are governed by the Plan Contract provided by Defendant to each enrollee.

213. Defendant has breached the contracts by failing to contract with a sufficient number of mental health providers to allow members to access timely in-network mental health services and failing to consistently provide an accurate provider directory.

214. In its contracts, Defendant agrees to "[c]over outpatient mental health care services . . . relating to the diagnosis and treatment of mental health conditions." The contract goes on to state that "Coverage for outpatient services for mental health care includes . . . services provided by a licensed psychiatrist or psychologist; a licensed clinical social workers; a licensed nurse practitioner; a licensed mental health counsel; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof."

215. The contracts direct members to the Healthfirst provider directory (which is published both online and in hard copy) to locate an in-network provider and guarantees that "The Provider directory will give You the following information about Our Participating Providers: Name, address, and telephone number; Specialty; Board certification (if applicable); Languages spoken; Whether the Participating Provider is accepting new patients." Healthfirst has consistently breached its contractual obligations to Plaintiffs and the Class by continuously misrepresenting and grossly exaggerating its provider network, including by falsely representing providers' in-

network status, availability to see new patients, qualifications, specialties, and other important information.

216. The contracts also provide that when a member "request[s] an appointment for outpatient mental health care or outpatient substance use services, a Participating Provider must offer You an appointment within . . . Ten (10) business days for an initial appointment."

217. The contracts further state that Healthfirst has "designated staff to assist You in finding a Participating Provider who can treat Your mental health condition or substance use disorder. You may contact Our designated staff by calling the number available on Our website."

218. When a member is unable to find an in-network provider and contacts Healthfirst by phone to submit an Access Complaint, Healthfirst is required within three days to locate a provider who is available within a reasonable distance and time to treat the member's mental health condition. If Healthfirst is unable to locate a provider within three days, it must notify the member of their right to receive a referral to an out-of-network provider. Services provided by this out-of-network provider must be covered by Healthfirst "as if they were provided by a Participating Provider."

219. On information and belief, each of Healthfirst's member contracts contains the provisions quoted above or substantially similar provisions.

220. Healthfirst breached its contracts with Plaintiffs and the Class by failing to provide meaningful coverage for outpatient mental health services. Because Healthfirst does not maintain an accurate provider directory, it has been impossible for Plaintiffs to locate in-network care and therefore make use of the coverage supposedly provided.

221. Healthfirst also breached its contracts with Plaintiffs and the Class by failing to adhere to the protocol established by the contracts for resolving Access Complaints. For example,

after struggling to locate an in-network psychiatrist, Mr. Greene contacted Healthfirst by phone and complained about his inability to access in-network care. Rather than providing assistance in locating a provider, Healthfirst told Mr. Greene that it was obligated only to direct him to in-network providers who could potentially prescribe his medication, not providers who were actually available to do so. In other words, Healthfirst claimed that its only responsibility was to identify providers who were in its network. If those providers were not available to serve Mr. Greene, Healthfirst would provide no further assistance.

222. Mr. Greene never received any follow-up communications from Healthfirst regarding his complaint. He did not receive any notice that he had the right to obtain a referral to an out-of-network provider whose services would be covered as if rendered by an in-network provider.

223. Members of the Class (including Plaintiffs) were damaged in several ways. The following is a non-exhaustive list of the types of damage incurred. First, they did not receive the benefits they were entitled to as members of the plan (most notably, access to the supposedly broad network of available providers). Second, they used out-of-network providers and paid those providers' out-of-network fees for care. Even after the plan reimbursed them the out-of-network allowed amount, these members typically incurred hundreds of dollars in out-of-pocket cost each time they received treatment – a cost far above their expected copay amount. Third, they abandoned their search for care, paying a premium for a service they were supposed to receive and did not, and incurring pain and suffering due to the unsuccessful provider search and their inability to receive treatment.

THIRD CAUSE OF ACTION

Breach of the Implied Covenant of Good Faith and Fair Dealing

224. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

225. Plaintiffs and Defendant have a direct contractual relationship.

226. The contract includes an implied covenant, actionable in contract, that Defendant will act in good faith and deal fairly with Plaintiffs.

227. Defendant materially breached the implied covenant in several respects, including but not limited to the following:

a) Defendant has failed to make a good-faith effort to maintain an up-to-date network directory;

b) Defendant has failed to maintain, and failed to make a good-faith effort to maintain, an adequate network of providers;

c) Defendant has presented providers as being in-network that were not, in fact, in-network;

d) Defendant has denied claims and/or failed to pay claims for providers that were listed as in-network in the directory; and

e) Defendant has failed to comply with all applicable laws.

228. Defendant's breaches were conscious and deliberate acts, which were designed to and did unfairly frustrate the agreed common purposes of the contract and which disappointed Plaintiffs' and the Class's reasonable expectations by denying Plaintiffs and the Class the benefits of the contracts.

229. As a direct and proximate cause of Defendant's breach of the implied covenant of good faith and fair dealing, Plaintiffs and the Class have suffered damages including, but not

limited to, damages incurred for having to pay for services and claims that should have been covered by the insurance contracts.

FOURTH CAUSE OF ACTION

Deceptive acts and practices in violation of the New York Deceptive Acts & Practices Act, N.Y. Gen. Bus. Law ("GBL") § 349

230. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

231. Plaintiffs bring this claim individually and on behalf of the members of the proposed Class against Defendant for violations of GBL § 349.

232. Defendant violated GBL § 349 by failing to provide Plaintiffs and the Class with the accurate information about in-network providers required by federal law, including, but not limited to, the No Surprises Act, Public Health Service Act, Employee Retirement Income Security Act, and Internal Revenue Code.

233. GBL § 349 imposes liability on anyone who engages in "[d]eceptive acts or practices in the conduct of any business, trade, or commerce or in the furnishing of any service" in New York.

234. Plaintiffs are "persons" under GBL § 349(h).

235. Defendant's actions as set forth herein occurred in the conduct of business, trade, or commerce under GBL § 349(a).

236. Defendant has engaged in consumer-oriented conduct that has misled and harmed Plaintiffs and Class members in New York. The actions and practices alleged herein were directed at consumers of health insurance and were therefore consumer-oriented.

237. In the course of business, Defendant made deceptive affirmative misrepresentations and omissions to Plaintiffs and the Class by publishing and disseminating misleading

informational and marketing materials prior to and during the open enrollment periods. The provider directory itself, on which members and prospective members are directed to rely, inflates and misleads consumers regarding the breadth of the network and the availability of mental health providers.

238. False representations include, *inter alia*, that Defendant has an adequately sized network; that providers listed on the provider directory are in-network; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers with the listed qualifications offering the listed services; and that mental health care coverage is comprehensive.

239. Omitted and concealed from Defendant's representations were material and relevant facts that Plaintiffs and Class members would have used in selecting their health insurance plan, including, *inter alia*, the extent of inaccuracies in the provider directory; the true breadth of the provider network; the likelihood that a member seeking mental health care would have to obtain out-of-network treatment, and the costs of such services; and the number of hours and expenditures that would be needed to be made to find appropriate mental health care.

240. These representations and omissions, when considered as a whole from the perspective of a reasonable consumer, conveyed that Defendant's provider directory was, as federal law requires, accurate and broad, and that mental health care would be covered. A reasonable consumer would attach importance to such representations and would be induced to enroll in such a plan.

241. The misrepresentations and omissions alleged herein were materially misleading.

242. The acts and practices alleged herein are deceptive acts and practices covered under GBL § 349 and have caused Plaintiffs and Class members significant ascertainable monetary and

non-monetary injuries. Among other injuries, Defendant's deceptive acts and practices have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forgo crucial and necessary mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

243. Defendant willfully and knowingly violated GBL § 349. Its effort to include affirmative misrepresentations and omissions in its marketing materials and provider directory was in its financial interests to market its plan as comprehensive, including with respect to mental health coverage, to induce individuals to choose Defendant's plan over other plans and to create the appearance of network adequacy and compliance with federal law.

FIFTH CAUSE OF ACTION

False advertising in violation of the New York False Advertising Act, N.Y. Gen. Bus. Law § 350

244. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

245. Plaintiffs bring this claim individually and on behalf of the members of the proposed Class against Defendant for violations of the New York False Advertising Act, GBL § 350.

246. Defendant violated GBL § 350 by failing to provide Plaintiffs and the Class with the accurate information about in-network providers required by federal law, including, but not

limited to, the No Surprises Act, Public Health Service Act, Employee Retirement Income Security Act, and Internal Revenue Code.

247. GBL § 350 imposes liability on anyone who uses false advertising in the conduct of any business, trade, or commerce, or in the furnishing of any service in New York. "False advertising" includes "advertising, including labeling of a commodity . . . if such advertising is misleading in a material respect," taking into account "the extent to which the advertising fails to reveal facts material in the light of . . . representations [made] with respect to the commodity . . . ." GBL § 350-a(1).

248. Defendant's actions as set forth herein occurred in the conduct of business, trade, or commerce under GBL § 350.

249. Defendant has engaged in consumer-oriented conduct that has misled and harmed Plaintiffs and Class members in New York. The actions and practices alleged herein were directed at consumers of health insurance and were therefore consumer-oriented.

250. A cause of action based upon false advertising is appropriate because Defendant utilized false advertising to mislead Plaintiffs and the Class about its provider network and compliance with federal law regarding this subject.

251. In the course of business, Defendant falsely advertised the Gold Leaf Premier, Essential 200-250, Essential 1, Silver Leaf Premier Plus, and Medicaid Managed Care Plans to Plaintiffs and Class members by publishing and disseminating misleading informational and marketing materials prior to and during the open enrollment periods. The provider directory itself, on which members and prospective members are directed to rely, misleads consumers regarding the adequacy and size of Defendant's network and the availability of mental health providers.

252. False representations include that Defendant has an adequately sized network; that providers listed on the provider directory are in-network; that providers listed as accepting new patients actually accept new patients; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers with the listed qualifications offering the listed services; and that the mental health care coverage is comprehensive.

253. Omitted and concealed from the representations were material and relevant facts that Plaintiffs and Class members would have used in selecting their health insurance plan, including the extent of inaccuracies in the provider directory; the true breadth of the provider network; the likelihood that a member seeking mental health care would have to obtain out-of-network treatment, and the costs of such services; and the number of hours and expenditures that would be needed to be made to find appropriate mental health care.

254. These representations and omissions, when considered as a whole from the perspective of a reasonable consumer, conveyed that Defendant's provider directory was accurate and broad, and that mental health care would be covered. A reasonable consumer would attach importance to such representations and would be induced to enroll in such a plan.

255. The false advertising alleged herein was materially misleading.

256. The acts and practices alleged herein constitute false advertising covered under GBL § 350 and have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forgo crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and

Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

257. Defendant willfully and knowingly violated GBL § 350. Its effort to include affirmative misrepresentations and omissions in its marketing materials and provider directory was in its financial interests to market the Gold Leaf Premier, Essential 200-250, Essential 1, Silver Leaf Premier Plus, and Medicaid Managed Care Plans as comprehensively including mental health coverage to induce individuals to choose its plan over other plans and to create the appearance of network adequacy and compliance with federal law.

SIXTH CAUSE OF ACTION

Violation of New York Insurance Law § 4226

258. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

259. Insurance companies have a statutory obligation to provide accurate and complete information about their health insurance plans. Specifically, New York Insurance Law § 4226(a)(1) states in pertinent part: "No insurer authorized to do in this state the business of . . . health insurance . . . shall . . . issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts."

260. Defendant is liable under Section 4226 because (1) it is authorized to provide health insurance in New York; (2) it misrepresented to Plaintiffs and Class members that they would have comprehensive access to in-network mental health care, including that the mental health providers listed on the provider directory accepted its insurance plan, that these providers would be accessible and available, and more; (3) the misrepresentations were material; (4) Defendant knew that it had misrepresented the terms, benefits, and advantages of its plan and has long been on

notice of its provider directory deficiencies; (5) Defendant knew that its online resource, and other documents containing the misrepresentations, would be communicated to Plaintiffs and Class members, directly and indirectly; (6) Plaintiffs and Class members received such documents and learned of the misrepresentations, directly and indirectly; (7) Defendant did not abide by its representations; and (8) Plaintiffs and Class members were thereby injured.

261. Defendant issued statements via its website, its provider directory, and other documents that materially misrepresented—through affirmative misstatements as well as omissions—the comprehensiveness of the Gold Leaf Premier, Essential 200-250, Essential 1, Silver Leaf Premier Plus, and Medicaid Managed Care Plans and mental health care coverage.

262. These misrepresentations were material because network breadth and access to in-network mental health providers are an important feature of a health insurance plan, which influences health care enrollment decisions.

263. Plaintiffs and Class members have suffered economic and non-economic injuries as a result of Defendant's misconduct. Among other injuries, Defendant's deceptive acts and practices have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forgo crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

264. These violations of New York Insurance Law § 4226(a) were intentional and Defendant knowingly received premiums and other compensation as a result of such violations.

SEVENTH CAUSE OF ACTION

Fraudulent Misrepresentation

265. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

266. Insurance companies have a statutory and common law obligation to provide accurate and complete information about their health insurance plans.

267. Defendant made deceptive affirmative misrepresentations and omissions to Plaintiffs and Class members by publishing and disseminating misleading informational and marketing materials prior to and during the open enrollment periods. Defendant's misrepresentations were conveyed in Defendant's provider directory and other marketing materials. The provider directory itself, on which Plaintiffs, as well as other members and prospective members, were directed to rely and did rely, intentionally inflated and misled them regarding the breadth and adequacy of the network and the availability of mental health providers.

268. The omissions from these same materials include, *inter alia*, any reference to the limited number of mental health providers who are actually in-network with Defendant, accepted Defendant's insurance, and were available to see new patients, and to the fact that members and prospective members have to utilize out-of-network providers—and incur substantial costs—should they need mental health services.

269. False representations include, *inter alia*, that Defendant has an adequate network of providers; that providers listed on the provider directory are in-network; that providers listed as accepting new patients actually accept new patients; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers with the listed qualifications offering the listed services; and that mental health care coverage is comprehensive.

270. Omitted and concealed from the representations were material and relevant facts that Plaintiffs and Class members would have used in selecting their health insurance plan, including, *inter alia*, the extent of inaccuracies in the provider directory; the true breadth of the provider network; the likelihood that a member seeking mental health care would have to obtain out-of-network treatment, and the costs of such services; and the number of hours and expenditures that would be needed to find appropriate mental health care.

271. These misrepresentations and omissions were intended to, and did, induce reliance by Plaintiffs and Class members as to the services and benefits that would be delivered to them as a result of choosing Defendant's plan. Plaintiffs and Class members chose to enroll in Defendant's plan (instead of better, cheaper options) based on the lies Defendant told about its provider network. And Plaintiffs and Class members detrimentally relied on Defendant's inaccurate directory when searching for in-network providers.

272. Plaintiffs and Class members justifiably relied on Defendant's representations and omissions, as Defendant had unique knowledge of the facts underlying their representations.

273. These fraudulent misrepresentations and omissions, when considered as a whole from the perspective of a reasonable consumer, conveyed that Defendant's provider directory was accurate and broad, and that mental health care would be covered to the full extent that Defendant had represented. A reasonable consumer would—and Plaintiffs and Class members did—attach importance to such representations and were induced to enroll in Defendant's health insurance plan as a result.

274. These fraudulent misrepresentations and omissions alleged herein were intentional and materially misleading. Defendant intentionally led Plaintiffs and Class members to believe that its network of available providers was adequate and robust in order to induce them to enroll

in, and remain enrolled in, its plan and to prevent them from receiving promised care. Such deception was designed to, and did, allow Defendant to reap enormous financial gain through increased income (by way of premiums paid by Plaintiffs and Class members) and reduced costs (by way of delayed, forgone, and unreimbursed care and avoidance of the expenses that would be incurred by creating and maintaining a robust provider network and accurate provider directory).

275. These fraudulent misrepresentations and omissions have caused Plaintiffs and Class members significant ascertainable monetary and non-monetary losses. Among other injuries, Defendant's misrepresentations and omissions have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forgo crucial and necessary mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; caused Plaintiffs and Class members to reduce spending on necessities and other life costs; caused Plaintiffs and Class members to enroll in Defendant's plan, as opposed to better and/or cheaper plans; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

276. Defendant willfully and knowingly made the fraudulent misrepresentations and omissions alleged herein. Its effort to include affirmative misrepresentations and omissions in its marketing materials and provider directory was undertaken intentionally to induce individuals to choose its plan over other plans and to prevent them from obtaining covered care, thus increasing its profits.

EIGHTH CAUSE OF ACTION

Negligent Misrepresentation

277. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

278. Insurance companies have a statutory and common law duty to provide accurate and complete information about their health care plans.

279. Nevertheless, Defendant negligently misrepresented its provider network and the availability of mental health providers for members because it failed to provide accurate information with regard to the breadth, qualifications, availability, identities, and contact information of providers in its network.

280. After contacting Defendant directly by phone to report difficulties in locating available, in-network care, Defendant instructed Class members, including Plaintiff Greene, to use and rely on the online provider directory to find in-network providers.

281. Defendant's false representations include, *inter alia*, that it has an adequate network of providers; that providers listed on the provider directory are in-network; that providers listed as accepting new patients actually accept new patients; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers with the listed qualifications offering the listed services; and that mental health care coverage is comprehensive.

282. Omitted and concealed from Defendant's representations were material and relevant facts that Plaintiffs and Class members used, and would have used in selecting their health insurance plan, including, *inter alia*, the extent of inaccuracies in the provider directory; the true breadth of the provider network; the likelihood that a member seeking mental health care would

have to obtain out-of-network treatment, and the costs of such services; and the number of hours and expenditures needed to find appropriate mental health care.

283. Plaintiffs and the Class justifiably relied upon the information that Defendant provided. Plaintiffs and Class members chose to enroll in Defendant's plan (instead of better, cheaper options) based on the misinformation Defendant provided to them about its provider network. And Plaintiffs and Class members detrimentally relied on Defendant's inaccurate directory when searching for in-network providers.

284. Defendant has not used reasonable care or competence in providing accurate information about its network of providers and in publishing its provider directory.

285. As a direct and proximate cause of Defendant's negligent misrepresentations, Plaintiffs and Class members have sustained damages. Among other injuries, Defendant's negligent misrepresentations have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forgo crucial and necessary mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; caused Plaintiffs and Class members to reduce spending on necessities and other life costs; caused Plaintiffs and Class members to enroll in Defendant's plan, as opposed to better and/or cheaper plans; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

NINTH CAUSE OF ACTION

Unjust Enrichment

286. Plaintiffs incorporate by reference all allegations in this Complaint and restate them as if fully set forth herein.

287. Defendant has been and continues to be significantly and unjustly enriched as a result of its inaccurate provider directory and inadequate mental health provider network. Because it portrayed its provider network as comprehensive, Plaintiffs and countless other individuals selected Defendant's plan over other plans, paid substantial premiums (or, in the case of Essential Plan and Medicaid enrollees, directed those premiums to be paid by New York State), and did not receive the coverage or care to which they were entitled. As a result, Defendant's market share and profits increased and its costs decreased, thus unjustly enriching it at Plaintiffs' and Class members' expense. Defendant's lies artificially inflated the price of, and induced Plaintiffs to enroll in, Defendant's plan, which increased the premiums paid to Defendant.

288. Plaintiffs and Class members have conferred a benefit on Defendant by enrolling in its health insurance plans and thereby directing their medical premiums and capitated rate payments to Defendant.

289. Plaintiffs and Class members have further conferred a benefit on Defendant because Defendant's inaccurate and inadequate network forces Plaintiffs and Class members to pay a portion of the mental health care expenses that Defendant represented would be covered. Effectively, Defendant represents that its insurance broadly covers mental health care, including care from providers listed in their directory, yet its bait-and-switch tactics ensure that it does not pay the full costs of actually covering mental health care services.

290. Defendant has thus enriched itself by reaping the benefits of increased membership, while reducing or eliminating its own coverage, reimbursement, and other financial duties. This and other benefits were obtained at the expense of Plaintiffs and Class members, who did not receive the full value of what Defendant promised.

291. In addition, Defendant's inflated mental health provider network makes it appear that it complies with federal and state statutory and regulatory requirements that its provider network be sufficient, adequate, and accurately stated, thereby saving it the costs of actual compliance with these requirements and shielding it from government investigation, and the associated costs, at the expense of its members.

292. An unjust enrichment cause of action is appropriate because Defendant failed to make restitution to Plaintiffs and Class members for the economic and non-economic harms, including out-of-pocket costs unjustly incurred, and more.

293. It is inequitable and unjust for Defendant to retain the benefits from falsely portraying its provider network in a way that increases enrollment while decreasing Defendant's obligations to do exactly what it says it will with respect to providing coverage for mental health treatment.

294. These expenses and inconveniences should have been borne by Defendant. The profits made by Defendant as a result of its misconduct should be disgorged.

DEMAND FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that judgment be entered as follows:

a. declaring that the instant action may be maintained as a class action under Rule 23 of the Federal Rules of Civil Procedure, certifying the Class as requested herein, designating Plaintiffs as the Class Representatives, and appointing the undersigned counsel as Class Counsel;

b. awarding all injunctive relief permitted by law or equity;

c. awarding compensatory damages, restitution, disgorgement, and any other relief permitted by law or equity;

d. awarding statutory damages and penalties in addition to actual damages;

e. awarding treble damages;

f. awarding punitive damages in an amount deemed appropriate by the Court;

g. awarding Plaintiffs and the Class pre-judgment and post-judgment interest;

h. awarding Plaintiffs reasonable attorneys' fees and costs; and

i. awarding Plaintiffs and the Class such other relief as this Court may deem just and proper under the circumstances.

* * *

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a trial by jury.

Dated: February 6, 2026

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