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20 *Claudine Castillo, Candyce Marto,*  
21 *Kevin Maedel, and The Putative Class*

22 **UNITED STATES DISTRICT COURT**  
23 **NORTHERN DISTRICT OF CALIFORNIA**

24 JENNIFFER ROIZ, CLAUDINE )  
25 CASTILLO, CANDYCE MARTO, and )  
26 KEVIN MAEDEL on behalf of themselves )  
27 and all others similarly situated, )

28 Plaintiffs, )

v. )

29 CALIFORNIA PHYSICIANS' SERVICE )  
30 DBA BLUE SHIELD OF CALIFORNIA, )  
31 MAGELLAN HEALTH, INC., )  
32 MAGELLAN HEALTHCARE, INC., and )  
33 HUMAN AFFAIRS INTERNATIONAL )  
34 OF CALIFORNIA, )

35 Defendants. )

Case No.: 3:25-cv-09978-WHO

**FIRST AMENDED CLASS ACTION  
COMPLAINT**

**DEMAND FOR JURY TRIAL**

**CLASS ACTION**

1 Plaintiffs Jenniffer Roiz, Claudine Castillo, Candyce Marto, and Kevin Maedel (“Plaintiffs”)  
2 bring this class action for damages, equitable relief, and injunctive relief against CALIFORNIA  
3 PHYSICIANS’ SERVICE DBA BLUE SHIELD OF CALIFORNIA (“Blue Shield”), MAGELLAN  
4 HEALTH, INC., MAGELLAN HEALTHCARE, INC., and HUMAN AFFAIRS INTERNATIONAL  
5 OF CALIFORNIA (collectively, “Magellan,” and together with Blue Shield, “Defendants”). Plaintiffs  
6 allege the following based upon personal information as to allegations regarding themselves, their own  
7 investigation, and the investigation of their counsel, and on information and belief as to all other  
8 allegations.

### 9 INTRODUCTION

10 1. There is a mental health crisis in this country and in this state. It is afflicting men and  
11 women, children and adults, and people of all income levels and backgrounds. And it is exacerbated  
12 by Defendants, who have been misleading vulnerable individuals in need of qualified mental health  
13 providers by publishing a grossly inaccurate directory of doctors and therapists. These inaccurate  
14 directories are known as “ghost networks.”

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

17 3. When, contrary to the representations in the directory, there are very few—or no—  
18 accessible, available doctors in Defendants’ network, the network does not comply with state and  
19 federal network adequacy laws. Such grossly inaccurate listings in a directory also violate the No  
20 Surprises Act, the Mental Health Parity and Addiction Equity Act, Defendants’ contractual obligations  
21 to Plaintiffs (which, among other things, require Defendants to comply with federal and state law),  
22 and California state insurance and consumer protection laws.

23 4. Defendants engage in unfair competition and deceptive business practices by  
24 knowingly publishing an inaccurate and misleading provider directory. They do so for several reasons:  
25 1) a robust provider network is attractive to potential customers; 2) a seemingly robust directory of  
26 providers gives Defendants the appearance of compliance with state and federal network adequacy  
27 laws (without the costs associated with creating and maintaining an adequate network and accurate  
28

1 directory); and 3) when members forego care after a time-consuming and frustrating provider search,  
2 Defendants do not have to pay for the care the members would have received.

3 5. By publishing a provider directory in which the vast majority of providers do not exist,  
4 no longer practice, cannot be contacted through the information provided, are not actually in-network  
5 with Defendants, are not accepting new patients, and/or have other inaccurate information listed,  
6 Defendants actively harm their members, including Plaintiffs. When Defendants misrepresent their  
7 network, members like Plaintiffs pay inflated premiums for an insurance plan that does not actually  
8 offer an adequate provider network to meet their needs. Even when plan members pay no premium,  
9 when Defendants misrepresent their network, members enroll in an insurance plan that does not  
10 actually provide an adequate network to meet their needs. Many members, like Plaintiffs, have no  
11 choice but to utilize out-of-network providers, incurring thousands of dollars in expenses.

12 6. Plaintiffs' insurance policies claim to cover mental health care with a robust network  
13 of available mental health providers made available by Defendants. In reality, that network is  
14 threadbare: contrary to the representations in the provider directory, there are very few mental health  
15 providers in California who actually take the insurance, are in-network, and accept new patients. Thus,  
16 the promised coverage is largely non-existent. The failure by Defendants to provide an adequate  
17 network to meet members' needs is itself a violation of federal and state network adequacy laws.

18 7. The harms are not just financial. Defendants' lies about the accuracy of the provider  
19 directory also exacerbate members' mental health problems. The people using Defendants' provider  
20 directory, including Plaintiffs, are often desperate for mental health care for themselves or their loved  
21 ones. Members searching for care often spend countless hours calling providers that Defendants have  
22 represented as available, accessible, and in-network, only to find out that the providers are not (and  
23 have long not been) in Defendants' network, do not offer the services listed in Defendants' provider  
24 directory, are not qualified to provide those services, are not accepting new patients, or cannot be  
25 reached at the phone number listed by Defendants. Members, including Plaintiffs, often undertake  
26 this fruitless search while suffering from severe mental health crises.

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

4 9. This First Amended Complaint details misrepresentations, misstatements, and  
5 omissions by Defendants regarding their supposedly robust mental health provider network and the  
6 mental health benefits purportedly available to those, like Plaintiffs, who enrolled in Blue Shield's  
7 health insurance. These misrepresentations, misstatements, and omissions are made in Defendants'  
8 provider directory, marketing materials, plan documents, and other places described in this First  
9 Amended Complaint. For ease of reading, these misrepresentations, misstatements, and omissions are  
10 often phrased in the present tense. However, all of these misrepresentations, misstatements, and  
11 omissions are not only currently being made by Defendants, they were also made before and  
12 throughout Plaintiffs' enrollment in Blue Shield's health insurance.  
13

14 **JURISDICTION AND VENUE**

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

17 11. This Court also has jurisdiction over the subject matter of this action pursuant to  
18 28 U.S.C. § 1332(d)(2). The amount in controversy, exclusive of interest and costs, exceeds the sum  
19 or value of \$5,000,000 and at least one member of the proposed class is a citizen of a state other than  
20 Delaware, which is the state of citizenship of Defendants Magellan Health, Inc. and Magellan  
21 Healthcare, Inc.

22 12. Venue is proper in this Judicial District pursuant to 28 U.S.C. § 1391(b) because a  
23 substantial part of the events or omissions giving rise to the claim occurred in this Judicial District.  
24 Venue is also proper under 18 U.S.C. § 1965(a) because Defendants transact substantial business in  
25 this Judicial District.

26 13. Divisional Assignment: Assignment to the San Francisco or Oakland Division is proper  
27 under Civil Local Rules 3-2(c) and 3-2(d) because a substantial part of the events or omissions giving  
28 rise to Plaintiffs' claims occurred in Alameda County.

**THE PARTIES**

**I. Plaintiffs**

14. Plaintiff Jenniffer Roiz is a resident of Orange County, California. She has been enrolled in the Blue Shield Platinum Full PPO 0/10 OffEx plan since 2024.

15. Plaintiff Claudine Castillo is a resident of Solano County, California. She and her 16-year-old son have been enrolled in the Blue Shield San Francisco Health Service System Trio HMO plan since 2022.

16. Plaintiffs Candyce Marto and Kevin Maedel are residents of San Bernardino County, California. They are enrolled in the TRIO HMO Per Admit 20-250 plan through Mr. Maedel’s employer.

**II. Defendants**

17. Defendant California Physicians’ Services DBA Blue Shield of California (“Blue Shield”) is a nonprofit corporation incorporated and headquartered in Oakland, California, and registered to do business in California. It administers the Blue Shield of California health insurance plans.

18. Defendant Magellan Health, Inc. is a Delaware corporation headquartered in Arizona. It administers the mental health benefits for many of Blue Shield’s insurance plans.

19. Defendant Magellan Healthcare, Inc., is a Delaware corporation and a subsidiary of Defendant Magellan Health, Inc. headquartered in Arizona. It administers the mental health benefits for many of Blue Shield’s insurance plans.

20. Defendant Human Affairs International of California is a stock corporation incorporated in California and a subsidiary of Defendant Magellan Healthcare, Inc. It is registered to do business and headquartered in California. It administers the mental health benefits for many of Blue Shield’s insurance plans.

**BACKGROUND & CONTEXT**

**I. The Mental Health Crisis in America**

21. 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—

1 struggle with mental illness.<sup>1</sup> Mental health problems are even more prevalent in younger adults, with  
2 36.2% of adults ages 18–25 and 29.4% of adults ages 26–49 reportedly having a mental illness.  
3 Despite this prevalence, roughly half (49.4%) of the 59.3 million adults living with mental illness have  
4 not received mental health treatment within the last year.<sup>2</sup>

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

10 23. According to the Centers for Disease Control and Prevention (“CDC”), among  
11 adolescents aged 12 to 17 years old, 20.9% have had a major depressive episode; among high school  
12 students, 36.7% have had persistent feelings of sadness or hopelessness, and 18.8% have attempted  
13 suicide.<sup>5</sup>

14 24. With the rates of pediatric self-harm and suicide rising dramatically,<sup>6</sup> the Surgeon  
15 General of the United States has described mental health as “the defining public health crisis of our  
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20 <sup>1</sup> National Institute of Mental Health, *Mental Illness Statistics*,  
21 <https://www.nimh.nih.gov/health/statistics/mental-illness>.

22 <sup>2</sup> *Id.*

23 <sup>3</sup> *Id.*

24 <sup>4</sup> *Id.*

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

28 <sup>6</sup> 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% increase in suicide among young  
Americans from 2009 to 2019, and a staggering 329% increase in pediatric self-harm visits from 2007  
to 2016).

1 time,”<sup>7</sup> and urged that “every child ha[ve] access to high-quality, affordable, and culturally competent  
2 mental health care.”<sup>8</sup>

3 25. Despite the “profound” consequences of untreated mental illness in children and  
4 adolescents, which are associated with “school failure, teenage pregnancy, unstable employment,  
5 substance use, violence including suicide and homicide, and poor medical outcomes,”<sup>9</sup> the CDC  
6 estimates that only approximately 20% of children with a mental, emotional, or behavioral disorder  
7 receive care from a specialized mental health provider.<sup>10</sup>

## 8 **II. Federal and State Requirements for Health Insurers**

### 9 **A. Insurance Companies Must Ensure Accuracy of Provider Directories**

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

12 27. The No Surprises Act, which became effective in 2022, requires insurers to update and  
13 verify their plans’ provider directories at least every 90 days.<sup>11</sup> Where plans are unable to verify  
14 provider data, they must establish a procedure to remove unverified providers from their directories.<sup>12</sup>  
15 Health plans must also update provider information within two business days of receiving an update  
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19 <sup>7</sup> Matt Richtel, *The Surgeon General’s New Mission: Adolescent Mental Health*, *N.Y. Times*, (Mar. 21,  
20 2023), <https://www.nytimes.com/2023/03/21/health/surgeon-general-adolescents-mental-health.html>.

21 <sup>8</sup> Off. of the Surgeon Gen., *Protecting Youth Mental Health: The U.S. Surgeon General’s Advisory* at  
22 12 (2021), <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>.

23 <sup>9</sup> Am. Academy of Pediatrics, *School-Based Mental Health: Pediatric Mental Health Minute Series*,  
24 aap.org (last visited Mar. 24, 2026), <https://www.aap.org/en/patient-care/mental-health-minute/school-based-mental-health/>.

25 <sup>10</sup> Ctrs. for Disease Control & Prevention, *Improving Access to Children’s Mental Health Care* (last  
26 reviewed Mar. 8, 2023), <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>.

27 <sup>11</sup> 42 U.S.C. § 300gg-115(a)(2).

28 <sup>12</sup> *Id.*

1 from a provider.<sup>13</sup> When a member telephonically requests information about whether a provider is  
2 in-network, the plan must respond within one business day of the request.<sup>14</sup>

3 28. The Affordable Care Act likewise requires a health insurance company participating in  
4 the Affordable Care Act Marketplace to “publish an up-to-date, accurate, and complete provider  
5 directory, including information on which providers are accepting new patients, the provider’s  
6 location, contact information, specialty, medical group, and any institutional affiliations, in a manner  
7 that is easily accessible” to enrollees and prospective enrollees.<sup>15</sup> Further, the insurance provider must  
8 “identify providers that are not accepting new patients.”<sup>16</sup>  
9

10 29. California Insurance Code Section 10133.15 and Section 1367.27 of the Knox-Keene  
11 Act of 1975 (the “Knox-Keene Act”)<sup>17</sup> require insurers to “publish and maintain” a provider directory  
12 “with information on contracting providers that deliver health care services to the plan’s enrollees,  
13 including those that accept new patients.” This directory “shall not list or include information on a  
14 provider that is not currently under contract with the plan.” This directory must be made available  
15 online and upon request in hard copy to all members of the public. Insurers must update their  
16 directories “at least quarterly, or more frequently, if required by federal law,” and “at least  
17 weekly ... when informed” that a “provider is no longer accepting new patients,” a provider “is no  
18 longer under contract” for the plan, or that the provider’s practice location, contact information,  
19 license, or practice type has changed. Insurers are required to “take appropriate steps to ensure the  
20 accuracy of the information concerning each provider listed” and must investigate and rectify reported  
21 inaccuracies within 30 business days. The directory must include “both an email address and  
22 telephone number for members of the public and providers to notify the plan if the provider directory  
23 appears to be inaccurate,” and this contact information must be “disclosed prominently in the  
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25 <sup>13</sup> *Id.*

26 <sup>14</sup> 42 U.S.C. § 300gg-115(a)(3).

27 <sup>15</sup> 45 C.F.R. § 156.230(b)(2).

28 <sup>16</sup> 45 C.F.R. § 156.230(b)(1).

<sup>17</sup> Codified at California Health & Safety Code, section 1340 et seq.

1 directory” and on “the plan’s internet website.” The insurer must “establish and maintain a process”  
2 for individuals to report directory inaccuracies, which must include “a hyperlink on the plan’s provider  
3 directory internet website linking to a form where the information can be reported directly to the plan.”

4 30. These federal and state laws reflect that governments recognize the harmful  
5 consequences of inaccurate provider directories. Despite these legislative efforts to shield consumers  
6 from ghost networks, surprise bills, and inadequate in-network care, Defendants continue to violate  
7 these laws.

8 **B. Insurance Companies Must Maintain an Adequate Network of Providers**

9 31. Federal and state laws also require health plans to offer a network that includes an  
10 adequate number of available in-network providers to meet members’ needs.

11 32. The Affordable Care Act first established this network adequacy framework, requiring  
12 that all Qualified Health Plans maintain a network that is “sufficient in number and types of providers,  
13 including providers that specialize in mental health and substance use disorder services, to ensure that  
14 all services will be accessible without unreasonable delay.”<sup>18</sup>

15 33. In addition, the Mental Health Parity and Addiction Equity Act (“MHPAEA”), 42  
16 U.S.C. § 300gg-26, incorporated into the Affordable Care Act via 45 C.F.R. § 156.115, provides that  
17 mental health and substance use disorder benefits must not be provided on less favorable terms than  
18 medical and surgical benefits, specifically with respect to annual, aggregate, or lifetime limits on  
19 coverage, financial requirements, treatment limitations, and out-of-network coverage.<sup>19</sup> Similarly,  
20 California Health & Safety Code § 1374.72 requires that “[e]very health care service plan” that  
21 “provides hospital, medical, or surgical coverage shall provide coverage for medically necessary  
22 treatment of mental health and substance use disorders, under the same terms and conditions applied  
23 to other medical conditions.”

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27 <sup>18</sup> 45 C.F.R. § 156.230(a)(1)(ii).

28 <sup>19</sup> 29 U.S.C. §1185a(a); 42 U.S.C. § 300gg-26(a).

1 34. MHPAEA regulations provide that “all plan standards that limit the scope or duration  
2 of benefits for services are subject to the nonquantitative treatment limitation parity requirements.  
3 This includes restrictions such as geographic limits, facility-type limits, and network adequacy.”<sup>20</sup>

4 35. California Insurance Code Section 10133.54 and Section 1367.03 of the Knox-Keene  
5 Act require health insurers and health care service plans to provide members with timely access to  
6 care by, among other things, establishing and maintaining a provider network that “has adequate  
7 capacity and availability of licensed health care providers to offer insureds” appointments for mental  
8 health care “within 10 business days of the request for appointment.” When the insurer’s network is  
9 inadequate to meet this standard, the insurer is required to “arrange for the provision of services outside  
10 the insurer’s contracted network” at a cost to the member not exceeding “applicable in-network  
11 copayments, coinsurance, and deductibles.”

12 36. Section 2240.01 of Chapter 10 of the California Code of Regulations requires insurers  
13 to ensure that “there are mental health and substance use disorder professionals with skills appropriate  
14 to care for the mental health and substance use disorder needs of covered persons and with sufficient  
15 capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel  
16 distance of 15 miles of each covered person’s residence or workplace.” Further, the “network must  
17 adequately provide for mental health and substance use disorder treatment, including behavioral health  
18 therapy.” Within an insurer’s network, “there must be mental health and substance use disorder  
19 providers of sufficient number and type to provide diagnosis and medically necessary treatment  
20 through providers acting within their scope of license and scope of competence.” Insurers must also  
21 ensure that their plan members can access information about their mental health benefits, providers,  
22 and other relevant information by contacting the insurer. When medically appropriate care is not  
23 available from a qualified, in-network provider, the insurer must “arrange for the required care with  
24 available and accessible providers outside the network, with the patient responsible for paying only  
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27 <sup>20</sup> Ctrs. for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (last  
28 modified Mar. 13, 2026), <https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity>; see also 29 C.F.R. § 2590.712(c)(4).

1 cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a  
2 similar service in-network.”

3 37. By inflating their provider directories with inaccurate listings, insurers, including  
4 Defendants, appear to meet federal and state network adequacy requirements when in reality they do  
5 not.<sup>21</sup>

6 38. Before and throughout Plaintiffs’ enrollment in Blue Shield’s health insurance,  
7 Defendants have violated and continue to violate federal and state laws requiring network adequacy.

8 **C. ERISA Requires Covered Insurers and Plan Administrators to Meet Benefit**  
9 **Obligations, Uphold Fiduciary Responsibilities, and Provide Truth in Marketing**

10 39. The Employee Retirement Income Security Act of 1974 (“ERISA”) was enacted by  
11 Congress in 1974 in recognition of the proliferation of employee benefit plans that directly impacted  
12 the well-being of millions of employees.<sup>22</sup> The establishment of national standards for employee  
13 benefit plans was deemed necessary, in part, to guard against exploitation of beneficiaries due to  
14 asymmetric information regarding plans.<sup>23</sup>

15 40. ERISA requires insurers and plan administrators to provide coverage in accordance  
16 with their plans; to resolve claims in accordance with their plans; to uphold the fiduciary duties of  
17 loyalty and care in administering their plans; and to ensure that no false statements or representations  
18 are made in connection with the marketing or sale of a plan.<sup>24</sup>

19 41. The MHPAEA is incorporated into ERISA at 29 U.S.C. § 1185a and generally requires  
20 that plans offer equally favorable coverage for mental health benefits and medical and surgical  
21 benefits.

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22  
23 <sup>21</sup> *Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence*  
24 *of Ghost Networks*, U.S. Senate Fin. Comm. (May 3, 2023),  
25 [https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-](https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-directory-accuracy-to-reduce-the-prevalence-of-ghost-networks)  
26 [directory-accuracy-to-reduce-the-prevalence-of-ghost-networks](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  
27 Mental Health Care”).

28 <sup>22</sup> 29 U.S.C. § 1001(a).

<sup>23</sup> *Id.*

<sup>24</sup> 29 U.S.C. §§ 1104, 1132, 1149.

1           42. Section 720 of ERISA and Section 9820 of the Internal Revenue Code both require  
2 health insurers to verify and update their provider directories not less frequently than once every 90  
3 days, remove a provider from the directory when it is unable to verify the directory information for  
4 that provider, and update the directory within two days of receiving new information from a provider.

### 5 **III. Ghost Networks**

6           43. The harms of a mental health ghost network have been widely investigated and  
7 confirmed, including by *The New York Times*,<sup>25</sup> *The Washington Post*,<sup>26</sup> academics,<sup>27</sup> the American  
8 Medical Association,<sup>28</sup> the Government Accountability Office,<sup>29</sup> and more.<sup>30</sup>

9  
10 <sup>25</sup> Jay Hancock, *Insurers' Flawed Directories Leave Patients Scrambling for In-Network Doctors*,  
11 *N.Y. Times* (Dec. 3, 2016), <https://www.nytimes.com/2016/12/03/us/inaccurate-doctor-directories-insurance-enrollment.html>.

12 <sup>26</sup> Katherine Ellison, *73 doctors and none available: How ghost networks hamper mental health care*,  
13 *Wash. Post* (Feb. 19, 2022), <https://www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network/>.

14 <sup>27</sup> See, e.g., Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan  
15 Provider Directories*, 40 *Yale L. & Pol'y Rev.* 78 (2021).

16 <sup>28</sup> *Improving Health Plan Provider Directories*, CAQH & Am. Med. Ass'n., 3,  
17 [https://www.caqh.org/sites/default/files/other/CAQH-AMA\\_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf](https://www.caqh.org/sites/default/files/other/CAQH-AMA_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf) (finding that  
18 “more than half of patients use [the provider directory] to select a physician”) (hereinafter “Improving  
19 Health Plan Provider Directories”).

20 <sup>29</sup> *Mental Health Care Access Challenges for Covered Consumers and Relevant Federal Efforts*, U.S.  
21 Gov't Accountability Office, Report to the Chairman, Comm. on Fin., U.S. Senate, 2, (Mar. 2022),  
22 <https://www.gao.gov/assets/gao-22-104597.pdf>.

23 <sup>30</sup> See, e.g., Ellison, *supra* n.26; Jack Turban, *Ghost networks of psychiatrists make money for  
24 insurance companies but hinder patients' access to care*, Stat News (June 17, 2019),  
25 <https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/>; *Online  
26 Provider Directory Review Report*, Ctrs. for Medicare & Medicaid Servs., 1,  
27 [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/  
28 ProviderDirectoryReviewIndustryReportRound311-28-2018.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/ProviderDirectoryReviewIndustryReportRound311-28-2018.pdf); Cama et al., *Availability of  
29 Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, *Int'l J.  
30 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) (June 2020),

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

3 Directory errors cost consumers money and erode regulatory consumer  
4 safeguards. They deceive consumers about the value of the coverage they  
5 are purchasing by concealing plans' actual provider networks, subjecting  
6 consumers to predatory billing practices, and breaking the link between  
7 consumer choices and plan practices that undergirds much of the American  
8 health insurance regulatory structure.<sup>31</sup>

9 **A. The United States Senate Finance Committee Ghost Networks Hearings**

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

13 Calling psychiatrists within D.C. and Maryland, selected out of what  
14 was like a digital white-pages phone book, turned into one rejection  
15 after another ... I spent countless days and hours scouring the network,  
16 despite working long hours in a high-level management position. When  
17 was there time to find a psychiatrist? I had to make the time, though, as  
18 my job, and more importantly my life, depended on it.<sup>32</sup>

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

23 For those who are healthy and well educated, going through an inaccurate  
24 provider list and being told repeatedly that "we are not taking new patients,"  
25 "this provider has retired," "we no longer accept your insurance," or leaving  
26 a message with no one returning the call is at best frustrating. For people  
27 who are experiencing significant mental illness or substance use disorders,  
28 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

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<https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501>.

<sup>31</sup> Burman, *supra* n.27, at 85.

<sup>32</sup> Senate Hearings on Mental Health Care (Testimony of Keris Jän Myrick at 4–6), 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](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).

1 inaccurate provider list results in more rejection and failure, exacerbating  
2 these feelings. Some give up looking for care. Others delay care.<sup>33</sup>

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

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

12 [W]hen insurance companies host ghost networks, they are selling health  
13 coverage under false pretenses, because the mental health providers  
14 advertised in their plan directories aren't picking up the phone or taking new  
15 patients. In any other business, if a product or service doesn't meet  
16 expectations, consumers can ask for a refund ....

17 It's not hard to imagine how many Americans simply give up and go on  
18 struggling without the help they need....

19 If a student were writing an essay and 80 percent of their citations were  
20 incorrect or made up, they'd receive an "F." If a business gave the SEC  
21 false or incorrect information, it would face extremely severe consequences.  
22 So in my view insurance companies should face strict consequences if their  
23 products don't live up to the billing.<sup>34</sup>

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

26 MS. GILIBERTI: [A]bout 60 percent of the plans [being discussed] don't  
27 have out of network coverage, so if you get really frustrated and you pay on  
28 your own then they're not paying anything.

29 SENATOR WARREN: So the more the Medicare Advantage plan can  
30 frustrate you ... the more you'll just go somewhere else. And that means  
31 it's not money out of their pockets.... So, look, what we are really saying  
32 here is that it is in the financial interests of these ... plans to discourage

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

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

1 beneficiaries from accessing care ... Because here's the key that underlines  
2 this. Whatever insurers don't spend on care as a result of tactics like  
3 outdated provider directories or overly restrictive networks or inaccurate  
4 information, whatever they don't spend on care, they get to keep.<sup>35</sup>

5 **FACTUAL ALLEGATIONS**

6 **I. Plaintiffs' Needs for Mental Health Care**

7 **A. Jenniffer Roiz**

8 50. Plaintiff Jenniffer Roiz is a resident of Orange County, California.

9 51. Ms. Roiz has been enrolled in the Blue Shield Platinum Full PPO 0/10 OffEx plan since  
10 August 2024.

11 52. When enrolling in health coverage through her employer in August 2024, Ms. Roiz  
12 specifically selected Blue Shield's Platinum offering—the most expensive option—because she  
13 understood it to offer the most comprehensive coverage, including coverage for mental health care  
14 through a robust provider network. She was seeing a therapist weekly at the time she enrolled, so she  
15 selected the Platinum plan because it offered \$0 co-payment for in-network mental health services and  
16 Ms. Roiz believed she would be able to access the robust network of mental health care providers  
17 listed in the provider directory based on Defendants' representations of the provider network.

18 53. Ms. Roiz relied on Defendants' representations regarding the provider network made  
19 in Defendants' marketing materials, website, provider directory, and plan documents when deciding  
20 to enroll in the Blue Shield plan; and, once enrolled, to understand her benefits. In other words, she  
21 enrolled in the Blue Shield plan because of Defendants' representations regarding the provider  
22 network—representations that were incorrect.

23 54. When deciding to enroll in the Platinum PPO plan, Ms. Roiz relied on implicit and  
24 explicit representations by Defendants that the provider directory was robust and accurate, especially  
25 with respect to mental health providers. Having a wide choice of accessible mental health care  
26 providers is, and was, critically important to Ms. Roiz.

27 55. Ms. Roiz pays a premium of approximately \$200 per month for her insurance through  
28 Blue Shield.

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<sup>35</sup> Senate Hearings on Mental Health Care, *supra* n.32 (Testimony of Senator Elizabeth Warren at 41).

1           56.     After confirming that her existing therapist was in Blue Shield’s network and enrolling  
2 in Blue Shield’s Blue Shield’s Platinum Full PPO 0/10 OffEx plan, Ms. Roiz continued to see her  
3 therapist.

4           57.     Shortly after enrolling in her Blue Shield plan, Ms. Roiz’s therapist told her that her  
5 therapy claims were being denied because the therapist was “not in a covered area,” even though the  
6 therapist frequently saw patients with Blue Shield insurance.

7           58.     Ms. Roiz called Blue Shield to figure out what was going on. On the phone, a  
8 representative told Ms. Roiz that her therapist was not in-network. Ms. Roiz pushed back strongly  
9 and was transferred to a Magellan representative. The Magellan representative told Ms. Roiz that her  
10 existing therapist would be covered for three months with in-network pricing but after that, she would  
11 need to find an in-network therapist.

12           59.     After learning that she would no longer be able to see her existing therapist, Ms. Roiz,  
13 who had recently experienced two miscarriages, urgently needed to find a new provider who  
14 specialized in grief and postpartum depression. Although Defendants’ provider directory represented  
15 that there were in-network therapists located nearby who were taking new patients, when Ms. Roiz  
16 began calling those providers from the directory, she was unable to find a provider who was in-network  
17 and accepting new patients.

18           60.     Ms. Roiz searched Defendants’ provider directory by filtering for female practitioners  
19 who specialized in grief and were accepting new patients. Ms. Roiz called ten providers listed on  
20 Defendants’ directory. Contrary to the representations in the directory, all the providers she called  
21 were out of network, were unavailable to treat Ms. Roiz, or did not offer the services listed.

22           61.     After being unable to locate an available provider through the directory, Ms. Roiz  
23 called Blue Shield’s mental health line (which was operated by Magellan) to submit an Access  
24 Complaint. Ms. Roiz informed Defendants of her difficulty locating an available in-network provider  
25 based on the representations in the directory. Defendants’ representative initially referred Ms. Roiz  
26 back to the directory as the resource for locating available, in-network care. When Ms. Roiz told  
27 Defendants’ representative that she could not find an available provider in the directory (despite the  
28 directory’s representations that the providers were available), Defendants’ representative told her that

1 sometimes the online directory is not up to date and offered to send Ms. Roiz a hard copy. Ms. Roiz  
2 accepted the offer, but when she received the hard copy, she confirmed it was the same as the  
3 inaccurate online directory she had referenced initially. This devastated Ms. Roiz, who was  
4 experiencing severe post-partum depression and grief during this time, which was compounded by her  
5 fruitless and frustrating search for an available in-network mental health provider.

6 62. Defendants did not offer to find Ms. Roiz an available provider within ten business  
7 days as required by her contracts. *See* Blue Shield Request for Judicial Notice (“RJN”) Ex. 1 at 129–  
8 30 (Dkt. No. 42-1); RJN Ex. 2 at 131–32 (Dkt. No. 42-2). Nor did Defendants offer to extend the  
9 three-month period of coverage for her existing therapist at an in-network rate when they learned she  
10 had been unable to find an in-network provider through the provider directory, also required by her  
11 contracts. *See* RJN Ex. 1 at 129; RJN Ex. 2 at 131. Ms. Roiz received no follow-up communication  
12 from Defendants regarding her inability to find in-network care based on the inaccurate representations  
13 in the provider directory.

14 63. Because she was desperate for mental health support and unable to find care through  
15 Defendants’ directory, Ms. Roiz continued to see her existing therapist, paying \$150 out-of-pocket per  
16 weekly session. Eventually, unable to afford additional out-of-network care, she stopped seeing her  
17 therapist.

18 64. Ms. Roiz needed to re-enroll in a Blue Shield plan in 2025 because, among other  
19 reasons, she developed critical relationships with in-network, non-mental-health-care providers who  
20 understood her medical needs. That was the intended, or at least foreseeable, effect of Defendants’  
21 bait-and-switch scheme: lure people into their health insurance plan with false promises of mental  
22 health benefits, and by the time the next enrollment period comes around, they will be trapped by their  
23 (or their family members’) dependence on their existing medical providers and the difficulty of  
24 switching plans.

25 65. In early 2026, Ms. Roiz resumed her search for an in-network therapist. Ms. Roiz  
26 filtered the provider directory for therapists with availability to see new patients. Contrary to the  
27 representations in the directory, none of the six providers Ms. Roiz called were available to see new  
28 patients.

1           66. Ms. Roiz encountered no inaccurate information in Blue Shield’s directory of medical  
2 and surgical providers and found that directory to be much more reliable than Defendants’ directory  
3 of mental health providers.

4           67. Over the same time period during which Defendants failed to supply in-network mental  
5 health providers within a reasonable distance of Ms. Roiz’s residence, Ms. Roiz relied on Blue Shield’s  
6 provider directory to identify and receive treatment from in-network providers within a reasonable  
7 distance for a variety of types of medical care—including primary care, gastroenterology, and  
8 gynecology—without long wait times.

9           68. For example, in or about February 2025, Ms. Roiz was looking for a gastroenterologist.  
10 She searched for one in her area using Blue Shield’s online directory, identified and called one  
11 provider, and scheduled an appointment without any wait time.

12           69. On information and belief, over the same period, other members of the class relied on  
13 Blue Shield’s directory to identify in-network providers within a reasonable distance for analogous  
14 medical and surgical services—including physical therapy, orthopedics, pain management, neurology,  
15 cardiology, podiatry, dermatology, rheumatology, gastroenterology, oncology, immunology,  
16 anesthesiology, and internal medicine—and Blue Shield approved claims for these services.

17           **B. Claudine Castillo**

18           70. Plaintiff Claudine Castillo is a resident of Solano County, California.

19           71. Ms. Castillo and her 16-year-old son have been enrolled in the Blue Shield San  
20 Francisco Health Service System Trio HMO plan since 2022.

21           72. Ms. Castillo is enrolled in her plan through her employer. When deciding between the  
22 insurance plans offered by her employer, she opted for the Trio HMO plan because she was led to  
23 believe that Blue Shield offered the best coverage of the options available. She relied on Blue Shield’s  
24 misrepresentations about the breadth of the provider network, including for mental health care, when  
25 she decided to enroll in this plan.

26           73. Ms. Castillo relied on Defendants’ representations regarding the provider network  
27 made in Defendants’ marketing materials, website, provider directory, and plan documents when  
28 deciding to enroll in Blue Shield’s plan and, once enrolled, to understand her benefits. In other words,

1 she enrolled in the Blue Shield plan because of Defendants’ representations regarding the provider  
2 network—representations that were incorrect.

3 74. When deciding to enroll in her plan, Ms. Castillo relied on implicit and explicit  
4 representations by Defendants that the provider directory was robust and accurate, especially with  
5 respect to mental health providers. Ms. Castillo believed that she and her son would be able to access  
6 the purportedly robust network of mental health care providers supposedly available to provide in-  
7 network mental health care. Having a wide choice of accessible mental health care providers is, and  
8 was, critically important to Ms. Castillo.

9 75. Ms. Castillo pays a premium of approximately \$80 per month for her insurance, and  
10 her employer pays an additional \$1,760 per month.

11 76. Several months after enrolling in her Blue Shield plan, Ms. Castillo searched for a  
12 psychiatrist for herself. On or about February 22, 2022, Ms. Castillo called Blue Shield, who referred  
13 her to Magellan, and asked for a list of in-network psychiatrists near her home. During this time, Ms.  
14 Castillo was on medical leave from work and was experiencing a severe mental health crisis, so she  
15 needed a psychiatrist she could reach without driving a long distance and whom she could see in-  
16 person. She lives in a densely populated county in the Bay Area so she did not anticipate these criteria  
17 would be an issue. Magellan sent her a list of providers that were supposedly taking new patients, but  
18 all were unreasonably far away—over an hour by car from her home.

19 77. After reviewing that list and determining that all providers were too far away, Ms.  
20 Castillo called Magellan back the same day and a Magellan representative sent her another list, this  
21 time with providers 45 minutes away. That was also too far, but because of her acute need for mental  
22 health services, Ms. Castillo called all 14 providers on that list. Contrary to Defendants’  
23 representations, all the providers were out of network, were unavailable to treat her, or did not offer  
24 the services she required. Unable to find an in-network provider within an hour’s drive from her home  
25 who was accepting new patients, Ms. Castillo abandoned her search for a psychiatrist and went without  
26 mental health care for over two years.

27 78. Ms. Castillo needed to re-enroll in her Blue Shield plan because, among other reasons,  
28 she developed critical relationships with in-network, non-mental-health-care providers who

1 understood her medical needs. That was the intended, or at least foreseeable, effect of Defendants'  
2 bait-and-switch scheme: lure people into their health insurance plan with false promises of mental  
3 health benefits, and by the time the next enrollment period comes around, they will be trapped by their  
4 (or their family members') dependence on their existing medical providers and the difficulty of  
5 switching plans.

6 79. On or about May 9, 2024, Ms. Castillo resumed her search for a psychiatrist. As she  
7 had done before, Ms. Castillo called Blue Shield, who referred her to Magellan, and requested a list  
8 of providers that were in-network. Again, Magellan sent a list of providers that were all over an hour  
9 by car from her home, including several that were almost two hours away.

10 80. On or about May 13, 2024, Ms. Castillo called Magellan *again* to request a list of in-  
11 network psychiatrists, stating specifically that she was looking for a provider within a reasonable  
12 distance of her home. This time, Magellan sent a list that included a psychiatrist with an address near  
13 her home. Ms. Castillo called that psychiatrist and made an appointment with him. Ms. Castillo has  
14 seen this psychiatrist regularly over the past two years but has only seen him three times in-person  
15 since his primary office was not located at the address listed in the directory and is not near her home.

16 81. Although Ms. Castillo eventually found a single provider to provide in-network  
17 psychiatry care (despite the provider directory showing a more robust provider network), she went  
18 without care for two years because she could not locate a single in-network provider (despite  
19 representations in Defendants' directory that there were available providers near her).

20 82. In August 2025, Ms. Castillo's son told her that he was considering suicide. Desperate  
21 to find mental health care for him, she called Blue Shield, who referred her to Magellan, told them  
22 that her son was suicidal, and asked for assistance in locating an available provider in her area.

23 83. On or around September 2, 2025, Magellan sent Ms. Castillo several lists of providers,  
24 most of whom were over an hour by car from her home. Ms. Castillo's son is in school until 3:00 pm  
25 and most providers' offices close at 5:00 pm, so he would not have been able to attend an hour-long  
26 appointment over an hour away within business hours. Additionally, Ms. Castillo works in San  
27

28

1 Francisco, so she is not able to pick her son up from school and drive over an hour each way every  
2 week to take him to therapy.

3 84. Ms. Castillo called the providers who were within 45 minutes of her home, all of whom  
4 the directory represented as taking new patients. Contrary to what the directory represented, all the  
5 providers Ms. Castillo called were out of network, were unavailable to treat her son, or did not offer  
6 the services that Ms. Castillo's son required.  
7

8 85. A month later, on or about October 1, 2025, Ms. Castillo called Magellan again for a  
9 list of available providers for her son in her area. Again, the list was largely compromised of providers  
10 over an hour from her home by car. On or about October 14, 2025, Ms. Castillo called Magellan yet  
11 again, with the same result (the list Magellan sent was almost all the same providers that it had already  
12 provided Ms. Castillo).

13 86. During her phone calls with Magellan, Ms. Castillo repeatedly emphasized that her  
14 suicidal son could not travel over two hours round trip to see a provider because he could not miss  
15 school. She asked representatives whether there was any way for her son to see someone out-of-  
16 network who could be covered as in-network because there were no available providers within a  
17 reasonable distance. The representatives told Ms. Castillo that there was nothing more they could do  
18 besides send the provider directory. Despite Ms. Castillo's explanation that her son was considering  
19 suicide and needed mental health care urgently, the Magellan representatives, acting on Blue Shield's  
20 behalf, said they could not help her son find care.

21 87. Defendants did not offer to find Ms. Castillo's son an available provider within 48  
22 hours as required by her contracts. *See* RJN Ex. 4 at 100 (Dkt. No. 42-4). Nor did Defendants offer  
23 to cover an out-of-network provider as in-network as her contract requires in these circumstances. *See*  
24 *id.* at 59, 100. Instead, Magellan told her there were no other in-network providers in her area (which  
25 contradicted Defendants' directory) and that she and her son would need to be willing to travel farther  
26 for care. Ms. Castillo received no follow-up communication from Defendants regarding her inability  
27 to find care for herself or her son.  
28

1 88. By December 2025, Ms. Castillo stopped calling Blue Shield and Magellan and instead  
2 began looking at Defendants' provider directory online. Many of the providers she called months  
3 earlier who did not have availability were listed in Defendants' directory as accepting new patients.  
4 Expecting that Defendants had updated the directory with new information since she initially called,  
5 Ms. Castillo called these providers again and discovered that they still did not have any availability,  
6 contrary to the representations in the directory. Ms. Castillo informed Magellan representatives that  
7 many providers listed in the directory as available actually had no availability. Even after informing  
8 Magellan of the inaccuracies, many of those same providers are still listed in the directory as available  
9 to see new patients.

10 89. To date, Ms. Castillo has not been able to find in-network care for her son, even though  
11 the provider directory falsely lists multiple available in-network providers. She has looked into out-  
12 of-network providers but cannot afford the \$200/session that would cost. Ms. Castillo wants to find  
13 her son a high-quality therapist so that he has a trusted adult to talk to who is not a parent or affiliated  
14 with his school. But because of Defendants' ghost network, she has been unable to do so.

15 90. Ms. Castillo found Blue Shield's directory of medical and surgical providers to be  
16 much more reliable and accurate than Defendants' directory of mental health providers.

17 91. Over the same time period during which Defendants failed to supply in-network mental  
18 health providers within a reasonable distance of Ms. Castillo's residence, Ms. Castillo relied on Blue  
19 Shield's provider directory to identify and receive treatment from in-network providers within a  
20 reasonable distance for a variety of types of medical care, including primary care, endocrinology, and  
21 podiatry.

22 92. On information and belief, over the same period, other members of the class relied on  
23 Blue Shield's directory to identify in-network providers within a reasonable distance for analogous  
24 medical and surgical services—including physical therapy, orthopedics, pain management, neurology,  
25 cardiology, podiatry, dermatology, rheumatology, gastroenterology, oncology, immunology,  
26 anesthesiology, and internal medicine—and Blue Shield approved claims for these services.

27 **C. Candyce Marto**

28 93. Plaintiff Candyce Marto is a resident of San Bernardino County, California.

1 94. Ms. Marto is enrolled in the Blue Shield TRIO HMO Per Admit 20-250. She and her  
2 husband, Kevin Maedel, have been enrolled in a Blue Shield HMO plan through his employer. She  
3 and her husband pay approximately \$100 per month for their coverage.

4 95. When deciding between the insurance plans offered by her husband’s employer, Ms.  
5 Marto and her husband opted for this plan because they were led to believe that Blue Shield offered  
6 the best coverage of the options available. She relied on Defendants’ misrepresentations about the  
7 breadth of the provider network when she decided to enroll in this plan.

8 96. Every year during open enrollment, Ms. Marto (together with her husband Mr. Maedel)  
9 reviews Blue Shield’s website to look at the robustness of Defendants’ network and its representations  
10 about what it will cover.

11 97. Both Ms. Marto and Mr. Maedel are teachers in Upland County public schools, and  
12 teaching classes remotely during the COVID-19 pandemic took a toll on their mental health.

13 98. Ms. Marto and Mr. Maedel have paid particular attention to Defendants’  
14 representations about the scope of their mental health coverage when deciding which plan to select  
15 during open enrollment.

16 99. Ms. Marto relied on Defendants’ representations regarding the provider network made  
17 in Defendants’ marketing materials, website, provider directory, and plan documents when deciding  
18 to enroll in the Blue Shield plan and, once enrolled, to understand her benefits. In other words, Ms.  
19 Marto and Mr. Maedel enrolled in the Blue Shield plan because of Defendants’ representations  
20 regarding the provider network—representations that were incorrect.

21 100. When deciding to enroll in her plan, Ms. Marto relied on implicit and explicit  
22 representations by Defendants that the provider directory was robust and accurate, especially with  
23 respect to mental health providers. Having a wide choice of accessible mental health care providers  
24 is, and was, critically important to Ms. Marto.

25 101. In 2022, after experiencing challenging medical issues, Ms. Marto decided to look for  
26 regular talk therapy providers. Blue Shield’s website redirected Ms. Marto to a provider directory  
27 hosted on Magellan’s website. There, she input her search criteria, and Magellan generated a list of  
28 hundreds of supposedly nearby, available, in-network providers.

1 102. Once she began calling providers from the list, however, it became clear that the search  
2 was futile. Contrary to the representations in the directory, all 15 providers she called were out of  
3 network, were unavailable to treat Ms. Marto, or did not offer the services listed in the directory.

4 103. Since she has been unable to locate an in-network provider based on the representations  
5 in the directory and unable to afford out-of-network care for which her plan offers no coverage, she  
6 has gone without care for the last four years.

7 104. Ms. Marto and Mr. Maedel needed to re-enroll in a Blue Shield plan because, among  
8 other reasons, they developed relationships with in-network, non-mental-health-care providers who  
9 understood their medical needs. That was the intended, or at least foreseeable, effect of Defendants'  
10 bait-and-switch scheme: lure people into their health insurance plan with false promises of mental  
11 health benefits, and by the time the next enrollment period comes around, they will be trapped by their  
12 (or their family members') dependence on their existing medical providers and the difficulty of  
13 switching plans.

14 105. Ms. Marto found Blue Shield's directory of medical and surgical providers to be much  
15 more reliable and accurate than Defendants' directory of mental health providers.

16 106. Over the same time period during which Defendants failed to supply in-network mental  
17 health providers within a reasonable distance of Ms. Marto's residence, Ms. Marto relied on Blue  
18 Shield's directory to identify and receive treatment from in-network providers within a reasonable  
19 distance for primary care, pulmonology, urology, and radiology services.

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

25 **D. Kevin Maedel**

26 108. Plaintiff Kevin Maedel is a resident of San Bernardino County, California.  
27  
28

1           109. Mr. Maedel is enrolled in the Blue Shield TRIO HMO Per Admit 20-250. He and his  
2 wife, Candyce Marto, have been enrolled in a Blue Shield HMO plan through his employer. They pay  
3 approximately \$100 per month for their coverage.

4           110. When deciding between the insurance plans offered by his employer, Mr. Maedel and  
5 his wife opted for this plan because they were led to believe that Blue Shield offered the best coverage  
6 of the options available. He relied on Blue Shield’s misrepresentations about the extent of coverage  
7 and the breadth of the provider network when he decided to enroll in this plan.

8           111. Mr. Maedel relied on Defendants’ representations regarding the provider network made  
9 in Defendants’ marketing materials, website, provider directory, and plan documents when deciding  
10 to enroll in Blue Shield’s plan and, once enrolled, to understand his benefits. In other words, he  
11 enrolled in the Blue Shield plan because of Defendants’ representations regarding the provider  
12 network—representations that were incorrect.

13           112. When deciding to enroll in this plan, Mr. Maedel relied on implicit and explicit  
14 representations by Defendants that the provider directory was robust and accurate, especially with  
15 respect to mental health providers. Having a wide choice of accessible mental health care providers  
16 is, and was, critically important to Mr. Maedel.

17           113. Mr. Maedel has been searching for a therapist for the last several years using the  
18 provider directory. During these searches, Ms. Marto used the Blue Shield and Magellan websites to  
19 generate a list of supposedly in-network, available providers. Mr. Maedel then called those providers  
20 to schedule an appointment. Contrary to the representations in the directory, the providers were out  
21 of network, were unavailable to treat him, or did not offer the services listed in the directory.

22           114. After he was unable to find a therapist by calling providers listed in the directory, Mr.  
23 Maedel’s primary care provider (“PCP”) referred him to a therapist during the summer of 2024. That  
24 therapist turned out to work at a substance abuse-focused practice, and Mr. Maedel has no substance  
25 abuse problems. He explained this to the representative from that practice who called him, but they  
26 did not seem to believe him and called him back multiple times angrily asking when he would come  
27 in for treatment. Mr. Maedel told his PCP about this experience and asked for another referral. His  
28

1 PCP said he could not provide any other referrals and told Mr. Maedel to look on Blue Shield and  
2 Magellan’s website.

3 115. Mr. Maedel was insulted and hurt by this experience. He was not a drug addict; he was  
4 experiencing stress and anxiety as a result of his job as a special education teacher and wanted to work  
5 with someone to develop coping skills. Instead, he felt guilty and rejected for seeking a therapist and  
6 the process of searching only increased his already high stress level.

7 116. Mr. Maedel searched for therapists again during the summer of 2025. Ms. Marto  
8 helped him generate lists of providers from the Magellan website, then sent him those lists. Ms. Marto  
9 filtered for providers within twenty miles of their home who were accepting new patients. Mr. Maedel  
10 spent five hours researching providers and their specializations, reading reviews, and calling and  
11 leaving voicemails for providers.

12 117. This search yielded the same results as the previous one: contrary to the representations  
13 in the directory, all the providers he called were out of network, were unavailable to treat him, or did  
14 not offer the services listed.

15 118. Mr. Maedel has gone without care for two years because he could not locate an in-  
16 network provider despite representations in Defendants’ directory that there were available providers  
17 near him.

18 119. In total, Mr. Maedel contacted more than 20 providers listed in the directory, none of  
19 whom were available to provide care. To date, Mr. Maedel has not been able to find an available, in-  
20 network provider for mental health care.

21 120. Ms. Marto and Mr. Maedel needed to re-enroll in a Blue Shield plan because, among  
22 other reasons, they developed relationships with in-network, non-mental-health-care providers who  
23 understood their medical needs. That was the intended, or at least foreseeable, effect of Defendants’  
24 bait-and-switch scheme: lure people into their health insurance plan with false promises of mental  
25 health benefits, and by the time the next enrollment period comes around, they will be trapped by their  
26 (or their family members’) dependence on their existing medical providers and the difficulty of  
27 switching plans.

28

## 1 II. Defendants' Ghost Network

### 2 A. Blue Shield's Partnership with Magellan

3 121. Blue Shield is a health care service plan under the Knox-Keene Act.

4 122. For many of its plans, including ERISA and non-ERISA plans, Blue Shield "contracts"  
5 with Magellan to "manage Mental Health and Substance Use Disorder services through [Magellan's  
6 own] network of providers." RJN Ex. 3 at 18 (Dkt. No. 42-3); RJN Ex. 4 at 18; RJN Ex. 7 at 17 (Dkt.  
7 No. 42-7); RJN Ex. 8 at 17 (Dkt. No. 42-8); RJN Ex. 9 at 17 (Dkt. No. 42-9); RJN Ex. 10 at 17 (Dkt.  
8 No. 42-10); *see also* RJN Ex. 1 at 66–67 ("Blue Shield's Mental Health Service Administrator  
9 (MHSA) administers Mental Health and Substance Use Disorder services from MHSA Participating  
10 Providers for Members in California."); RJN Ex. 2 at 66–67 (same).

11 123. For these plans, Magellan serves as the plan's Mental Health Service Administrator  
12 ("MHSA"). As the MHSA, Magellan administers mental health benefits on behalf of Blue Shield,  
13 including by "authoriz[ing] services, process[ing] claims, and address[ing] complaints and grievances  
14 for those Benefits on behalf of Blue Shield." RJN Ex. 1 at 26; RJN Ex. 2 at 26; RJN Ex. 3 at 18; RJN  
15 Ex. 4 at 18; RJN Ex. 7 at 17; RJN Ex. 8 at 17; RJN Ex. 9 at 17; RJN Ex. 10 at 17; *see also* RJN Ex. 1  
16 at 66–67 (the MHSA "administers Mental Health and Substance Use Disorder services from MHSA  
17 Participating Providers for Members in California"); RJN Ex. 2 at 66–67 (same).

18 124. Magellan is also a specialized health care service plan under the Knox-Keene Act. *See*  
19 RJN Ex. 1 at 124 ("The MHSA is a specialized health care service plan licensed by the California  
20 Department of Managed Health Care. Blue Shield contracts with the MHSA to administer Blue  
21 Shield's Mental Health and Substance Use Disorder services."); RJN Ex. 2 at 125 (same); RJN Ex. 3  
22 at 93 (same); RJN Ex. 4 at 95 (same); RJN Ex. 7 at 85 (same); RJN Ex. 8 at 90 (same); RJN Ex. 9 at  
23 93 (same); RJN Ex. 10 at 96 (same).

24 125. Blue Shield does not delegate responsibility over the administration of its medical and  
25 surgical benefits to Magellan or any other third party. Instead, Blue Shield manages its own network  
26 of medical and surgical providers, processes claims for medical and surgical services, and addresses  
27 complaints and grievances regarding those benefits in-house. In other words, Blue Shield uses  
28

1 different procedures for ensuring that its medical and surgical network includes an adequate number  
2 of each category of provider and facility than it does for its mental health and substance abuse network.

3 126. On information and belief, Blue Shield’s processes for ensuring network adequacy for  
4 mental health providers are less rigorous and less effective than the processes applied to  
5 medical/surgical providers.

6 127. On information and belief, Blue Shield devotes less time, energy, and money to  
7 ensuring the accuracy of its network for mental health providers than the accuracy of its network for  
8 medical/surgical providers.

9 **B. Blue Shield’s Plan Documents and Mental Health Coverage**

10 **i. Platinum Full PPO 0/10 OffEx Plan**

11 128. Blue Shield’s Platinum Full PPO 0/10 OffEx (“Platinum Full”) Plan is an ERISA plan  
12 that offers members access to low-cost care when using an in-network provider. Both individual and  
13 family members have no deductible for in-network care but have a \$1,000 individual and \$2,000  
14 family medical deductible for out-of-network care. The plan has an annual out-of-pocket maximum  
15 of \$4,700 for individuals using in-network providers and \$9,400 for a combination of in- and out-of-  
16 network providers. *See* RJN Ex. 1 at 4; RJN Ex. 2 at 4.

17 129. Members are responsible for a co-pay of \$10 per visit for outpatient mental health  
18 office visits when the provider is in-network with Blue Shield’s MHSA. *See* RJN Ex. 1 at 9; RJN Ex.  
19 2 at 9.

20 130. Other outpatient mental health services, including intensive outpatient care and  
21 behavioral health treatment for pervasive developmental disorders or autism, are subject to 10%  
22 coinsurance when provided by an in-network practitioner. *See* RJN Ex. 1 at 9; RJN Ex. 2 at 9.

23 131. For out-of-network behavioral healthcare, members must pay 40% coinsurance. *See*  
24 RJN Ex. 1 at 9; RJN Ex. 2 at 9.

25 132. The plan includes both inpatient and outpatient mental health coverage.

26 **ii. TRIO HMO Basic Plan**

1 133. The Blue Shield TRIO HMO Basic Plan is a non-ERISA plan offered by Blue Shield  
2 to some public employees of California pursuant to a contract between Blue Shield and the San  
3 Francisco Health Service System.

4 134. The plan’s annual out-of-pocket maximum for in-network medical costs is \$2,000 for  
5 individuals and \$4,000 for families. *See* RJN Ex. 3 at 5; RJN Ex. 4 at 5.

6 135. Outpatient mental health services require a \$25 copay per visit. Coverage only applies  
7 to services received from in-network providers, and the plan offers no coverage for out-of-network  
8 providers. *See* RJN Ex. 3 at 9; RJN Ex. 4 at 9.

9 136. The plan includes both inpatient and outpatient mental health coverage.

10 **iii. TRIO HMO Per Admit 20-250 Plan**

11 137. The TRIO HMO Per Admit 20-250 (“TRIO HMO 20-250”) Plan is a non-ERISA plan  
12 offered by Blue Shield to some public employees of California pursuant to a contract between Blue  
13 Shield and the Upland Unified School District.

14 138. The plan has no deductible when using an in-network provider but offers no coverage  
15 for out-of-network care. Individual coverage is subject to an annual out-of-pocket maximum of \$2,000  
16 for in-network care, while family coverage also has a separate \$4,000 family maximum. *See* RJN Ex.  
17 10 at 4.

18 139. For outpatient mental health services, members are responsible for a \$20 copay per  
19 office visit but only have coverage for providers that are in-network with the MHSA. *See id.* at 8.

20 140. The plan includes both inpatient and outpatient mental health coverage.

21 **C. Defendants’ Provider Directory**

22 141. Before Plaintiffs’ enrollment in Blue Shield’s health insurance (when Plaintiffs were  
23 deciding whether to enroll in this insurance) and throughout Plaintiffs’ enrollment in Blue Shield’s  
24 health insurance, Defendants have published an inaccurate directory of mental health providers who  
25 are supposedly in-network with Defendants, available to see new patients, and qualified to provide  
26 specified mental health services. Defendants’ provider directory is the definitive resource to identify  
27 which providers are in Defendants’ network and thereby covered at the plan’s in-network rate. This  
28 directory is publicly available to members and non-members of Blue Shield plans. The inaccurate

1 directory of mental health providers is published and publicly disseminated on Blue Shield’s website  
2 and on Magellan’s website as well as in hard copy. When searching for mental health providers on  
3 Blue Shield’s website, the website may redirect users to the directory on Magellan’s website.  
4 Regardless of which website users find themselves on, the inaccurate directory is published and  
5 controlled by both Blue Shield and Magellan.

6 142. The directory contains various information about supposedly in-network providers,  
7 including their location, contact information, education, experience, qualifications, credentials,  
8 hospital affiliations, services offered, whether they are accepting new patients, and whether they offer  
9 virtual or in-person appointments.

10 143. Defendants’ directory allows the user to input their location and search radius, and can  
11 be sorted based on provider gender, clinical focus, and whether a provider is accepting new patients  
12 or offers virtual or in-person appointments.

13 144. Both Blue Shield and Magellan use the provider directory—which is prominently  
14 displayed on their websites—to attract potential customers under false pretenses. Knowing that  
15 customers, like Plaintiffs, place great weight on the breadth of a mental health provider network when  
16 selecting their health insurance, Blue Shield and Magellan artificially inflate the breadth of their  
17 mental health provider network through their online and print directory. By publishing a directory  
18 that falsely portrays a robust mental health provider network, Defendants attempt to lure customers  
19 into enrolling in their health insurance, which enriches Defendants.

20 145. Defendants’ provider directory affirmatively misrepresents to current and prospective  
21 members that the mental health providers listed are in fact in-network and will be accessible and  
22 available to provide care. In reality, the vast majority of providers listed in the directory have ceased  
23 practicing or are not in-network, not available, not reachable, not qualified to provide the services  
24 listed, or not actually practicing at the listed location. Defendants’ misrepresentations regarding the  
25 breadth of their network occurred continuously before and throughout Plaintiffs’ enrollment in Blue  
26 Shield’s health insurance.

27 146. Moreover, Defendants’ provider directory is replete with other inaccuracies, including  
28 incorrect addresses and phone numbers, as well as repeated entries of the same provider. These

1 inaccuracies may appear at first glance to be a minor oversight, but such errors are far from trivial for  
2 a person who needs urgent mental health care for themselves or a loved one. The erroneous inclusion of  
3 such incorrect listings artificially inflates the perceived size and adequacy of Defendants’ network and  
4 forces members to invest more time and energy trying to find a mental health provider—only to be  
5 repeatedly led to a dead end. Although this is devastating to plan enrollees like Plaintiffs, it enriches  
6 Defendants by reducing the amount of insurance claims they need to cover.

7 147. For instance, as discussed above, Ms. Castillo noted that the same unavailable providers  
8 continued to be listed as taking new patients for months, even though Ms. Castillo confirmed that their  
9 availability had not changed. This remained true even after Ms. Castillo alerted Magellan  
10 representatives to the issue.

11 148. Blue Shield failed to verify provider information within the statutorily mandated  
12 timeframes, failed to remove providers who could not be verified, and failed to update the directory  
13 within the statutorily required period after learning of changes. Likewise, Magellan failed to verify  
14 provider information within the statutorily mandated timeframes, failed to remove providers who  
15 could not be verified, and failed to update the directory within the statutorily required period after  
16 learning of changes.

17 149. In marketing materials, plan documents, and member contracts, Defendants cite and  
18 incorporate by reference this grossly inaccurate directory. Blue Shield plan documents—which are  
19 contract documents—direct members to “[v]isit blueshieldca.com and click on Find a Doctor to access  
20 the MHSA Participating Provider network.” RJN Ex. 1 at 67; RJN Ex. 2 at 67; RJN Ex. 3 at 59; RJN  
21 Ex. 4 at 59; RJN Ex. 7 at 53; RJN Ex. 8 at 56; RJN Ex. 9 at 57; RJN Ex. 10 at 59. Plan documents  
22 also state, “You can find Participating Providers in this network at blueshieldca.com.” RJN Ex. 1 at  
23 4; RJN Ex. 2 at 4; RJN Ex. 3 at 5; RJN Ex. 4 at 5; RJN Ex. 7 at 4; RJN Ex. 8 at 4; RJN Ex. 9 at 4; RJN  
24 Ex. 10 at 4. The plan documents also direct enrollees to “[v]isit blueshieldca.com or use the Blue  
25 Shield mobile app to ... [f]ind a doctor or other Health Care Provider.” RJA Ex. 1 at 18; RJN Ex. 2 at  
26 18; RJN Ex. 3 at 12–13; RJN Ex. 4 at 13; RJN at Ex. 7 at 12; RJN Ex. 8 at 12; RJN Ex. 9 at 12; RJN  
27 Ex. 10 at 12; *see also* RJN Ex. 1 at 25 (“Visit blueshieldca.com or use the Blue Shield mobile app and  
28 click on **Find a Doctor** for a list of plan’s **Participating Providers**.” (emphasis in original)); RJN Ex.

1 2 at 25 (same); RJN Ex. 3 at 17 (same); RJN Ex. 4 at 17 (same); RJN Ex. 7 at 16 (same); RJN Ex. 8  
2 at 16 (same); RJN Ex. 9 at 16 (same); RJN Ex. 10 at 16 (same). Each page of Blue Shield plan  
3 documents refers members with questions to “[v]isit blueshieldca.com,” thus incorporating the online  
4 directory by reference. RJN Ex. 1; RJN Ex. 2; RJN Ex. 3; RJN Ex. 4; RJN Ex. 7; RJN Ex. 8; RJN Ex.  
5 9; RJN Ex. 10.

6 150. The directory makes it appear as if Defendants’ network is far more robust than it  
7 actually is and falsely represents that plan members have access to vastly more mental health providers  
8 than they actually do. Accordingly, Defendants’ provider directory and representations about their  
9 comprehensive mental health coverage are inaccurate, deceptive, and misleading.

10 **D. Ms. Roiz’s Denial of Benefits**

11 151. Blue Shield’s contract with Ms. Roiz designates Magellan as the MHSA, giving  
12 Magellan discretionary authority to approve and deny claims by Blue Shield members for mental  
13 health services. *See* RJN Ex. 1 at 26, 66–67; RJN Ex. 2 at 26, 66–67.

14 152. Because Magellan had the authority to approve and deny Ms. Roiz’s claims for mental  
15 health services, and not only perform ministerial functions, it was a fiduciary.

16 153. Defendants breached the terms of Blue Shield’s contract with Ms. Roiz, including by  
17 failing to “approve [her] request” to see an out-of-network provider since she “the services [she sought  
18 could not] reasonably be obtained from a Participating Provider.” RJN Ex. 1 at 30; RJN Ex. 2 at 30.

19 154. When Ms. Roiz sought assistance from Magellan, its representatives—who could not  
20 even determine whether her therapist was in-network—misled her. Magellan representatives  
21 repeatedly directed Ms. Roiz to consult the inaccurate provider directory, even though Ms. Roiz had  
22 told them that providers listed as available to see new patients were not actually available. The  
23 Magellan representatives did not tell Ms. Roiz that she could submit a grievance to seek an out-of-  
24 network exception, even though her plan documents direct members to “call Customer Service” when  
25 they have questions and that the “first step is to make an inquiry through Customer Service.” RJN Ex.  
26 1 at 96; RJN Ex. 2 at 87.

27 155. Compounding Ms. Roiz’s difficulty locating a contractually promised provider “who  
28 can provide the care you need close to home,” RJN Ex. 1 at 30; RJN Ex. 2 at 30, Magellan’s customer

1 service line closed at 5:00 pm. As a result, Ms. Roiz would spend several days repeatedly calling on  
2 her half-hour lunch breach, typically spending several hours over several days just to reach a  
3 representative. Moreover, Magellan representatives would not identify themselves as working for  
4 Magellan rather than Blue Shield. Only later did Ms. Roiz realize that Magellan is a separate entity  
5 that was making care and coverage decisions on behalf of Blue Shield.

6 156. In addition, Ms. Roiz was experiencing severe grief and post-partum depression after  
7 two miscarriages upon receiving this denial of coverage. She had already spent hours on the phone  
8 with Defendants’ representatives getting transferred back and forth and receiving contradictory  
9 information, which compounded her distress.

10 157. Magellan, acting on Blue Shield’s behalf, denied Ms. Roiz’s request for an extension  
11 of the three-month period covering her existing therapist as in-network, based on its finding that in-  
12 network providers were available. This finding was based on the false and inaccurate provider  
13 directory, which listed many providers within 25 miles of Ms. Roiz as available to see new patients.  
14 In reality, as Ms. Roiz had confirmed, these providers were not taking new patients.

15 158. This denial was contrary to the terms of Ms. Roiz’s plan, since there were no in-network  
16 providers available within a reasonable distance of Ms. Roiz.

17 159. The denial of Ms. Roiz’s claim, refusal to approve out-of-network services as covered  
18 services, and inconsistent and inadequate reimbursements violated the terms of her plan.

19 **E. “Secret Shopper” Studies**

20 **Jenniffer Roiz**

21 160. In February and March 2026, Plaintiffs’ counsel oversaw a secret shopper study to  
22 replicate Ms. Roiz’s experience trying to locate a provider. Counsel utilized research consultants to  
23 conduct this study using a methodology developed in conjunction with a prominent health policy  
24 academic. The consultants searched for the same type of care that Plaintiffs sought when searching  
25 for mental health care, whether a psychiatrist, a psychologist, or other type of therapist.  
26  
27  
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1 161. Using the online provider directory, the research consultants generated a list of  
2 supposedly in-network providers, specifically therapists, accepting new patients within a 20-mile  
3 radius of Santa Ana, California, where Ms. Roiz resides.<sup>36</sup>

4 162. The consultants then called a randomized sample of the listed providers. If a call was  
5 not answered, the consultants would make a second and third attempt over multiple days and would  
6 leave a voicemail asking for a return call after each attempt. For every completed call, the consultants  
7 recorded the provider's response: whether they were indeed the type of provider listed in the directory;  
8 whether they accepted Blue Shield; whether the provider was accepting new patients; and how long  
9 the wait was for an appointment.  
10

11 163. The study replicating Ms. Roiz's search yielded 201 providers within 20 miles. It was  
12 not possible to make an appointment with 41 of the total 50 directory listings called. In total, 18  
13 providers were unreachable. Of the 23 providers that were reachable, 19 did not accept Blue Shield,  
14 were not accepting new patients, did not provide the necessary services, and/or were retired. The  
15 research consultants were able to reach an additional four providers but were unable to confirm those  
16 providers' network status and availability by phone.  
17

18 164. That is an 80.4% ghost rate.

19 165. Plaintiffs' counsel conducted an earlier secret shopper study to replicate Ms. Roiz's  
20 experience trying to locate a provider in July 2025. That study resulted in an 87% ghost rate.  
21

22 **Claudine Castillo**  
23  
24  
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26

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27 <sup>36</sup> The Blue Shield provider search does not give users the option to filter for "therapist." Instead,  
28 users must choose a more specific provider type and cannot choose multiple provider types when  
conducting their search. The research consultants filtered for "psychologist" for this search.

1 166. The research consultants repeated the study steps to replicate Ms. Castillo’s search for  
2 a mental health provider, specifically, a therapist for an adolescent/minor.<sup>37</sup> This search yielded 23  
3 providers within 20 miles of Vallejo, California.<sup>38</sup>

4 167. Overall, it was not possible to make an appointment with 18 of the total 19 directory  
5 listings called. In total, 11 providers were unreachable. The remaining seven providers were  
6 reachable, but they did not accept Blue Shield, were not accepting new patients, did not provide the  
7 listed services, and/or would only offer appointments to those who were already patients at the  
8 provider’s clinic.

9 168. That is a 94.74% ghost rate.

10  
11 **Candyce Marto and Kevin Maedel**

12 169. In February 2026, the research consultants repeated the study steps to replicate Ms.  
13 Marto and Mr. Maedel’s experience trying to locate therapists.<sup>39</sup>

14 170. The provider search yielded 211 providers.<sup>40</sup> Overall, it was not possible to make an  
15 appointment with 44 of the total 50 directory listings called. In total, 16 providers were unreachable.  
16 Of the 28 providers that were reachable, 26 did not accept the insurance plan, were not accepting new  
17 patients, did not provide the necessary services, were no longer at the listed practice, and/or would  
18 only offer new appointments to those who had a primary care physician at the clinic. The research  
19

20  
21  
22  
23 <sup>37</sup> The research consultant chose “psychologist” to reflect the search for therapists and applied a filter  
for “adolescents.”

24 <sup>38</sup> The Blue Shield provider directory webpage showed that this search yielded 23 results. But the  
25 research consultant confirmed that, in reality, it had only yielded 19 results.

26 <sup>39</sup> As discussed above, Ms. Marto and Mr. Maedel are a married couple. They reside in the same home  
27 and are on the same insurance plan. They were also both seeking therapists. As a result, Plaintiffs’  
counsel conducted one secret shopper study for the two of them.

28 <sup>40</sup> The Blue Shield provider directory webpage showed that this search yielded 251 results. But the  
research consultant confirmed that, in reality, it had only yielded 211 results.

1 consultants were able to reach an additional two providers but were unable to confirm those providers’  
2 network status and availability by phone.

3 171. That is an 87.5% ghost rate.

4 **III. Defendants’ Deceptive and Misleading Activity**

5 **A. Defendants’ Misrepresentations and Omissions**

6 172. For ease of reading, the misrepresentations and omissions outlined in this Amended  
7 Complaint are generally phrased in the present tense. However, all of these misrepresentations and  
8 omissions are not only currently being made, they were also made before and throughout Plaintiffs’  
9 enrollment in Blue Shield’s health insurance.

10 173. Defendants hold themselves out to consumers—through the provider directory and  
11 marketing materials—as having a robust network of available providers to meet members’ mental  
12 health care needs. These representations are deceptive, as the directory misrepresents the breadth of  
13 the network and the ease of utilizing the benefits available under the insurance plan.

14 174. In addition to publishing and maintaining an inaccurate provider directory, Defendants  
15 provide consumers with deceptive and materially misleading marketing and program materials about  
16 the benefits offered under their plans. These materials promise mental health benefits, easy access to  
17 care, and a robust network of providers who have availability to see new patients. For example, in its  
18 Evidence of Coverage for the Platinum Full Plan, Blue Shield states that “A Blue Shield health plan  
19 will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and  
20 other Health Care Providers.”<sup>41</sup> RJN Ex. 1 at 17; RJN Ex. 2 at 17.

21 175. Plaintiffs decided to enroll in their insurance plans based on representations that they  
22 would have access to a robust network of providers, including mental health providers, adequate to  
23 meet their healthcare needs.  
24

25  
26 \_\_\_\_\_  
27 <sup>41</sup> Defendants also encourage members and prospective members to rely on Evidence of Coverage  
28 documents by stating that they should “read [the] Evidence of Coverage and Disclosure Form carefully  
and completely so that you understand which services are covered health care services, and the  
limitations and exclusions that apply to your plan.”

1 176. When deciding to enroll in Blue Shield’s health insurance, Plaintiffs relied on implicit  
2 and explicit representations that the mental health provider network was robust and accurately  
3 reflected in the directory.

4 177. On a web page titled “Blue Shield’s network,” Blue Shield says that “[o]ur network of  
5 doctors and hospitals is designed to meet the needs of members ... A full selection of behavioral health  
6 providers for mental health care and substance use treatment are available. Additional specialists are  
7 included in our network if they meet our credentialing requirements to help make sure members have  
8 access to a larger number of doctors within a reasonable distance from home.” This page then directs  
9 the user to Blue Shield’s directory page to “Find a doctor.”

10 178. Blue Shield repeatedly directs members seeking mental health care to its “Find a  
11 doctor” tool and to call Blue Shield for assistance: “If you need help finding behavioral health support,  
12 Find a doctor can help you search for in-network providers covered by your benefit plan. If you can’t  
13 find the provider or service you’re looking for—or want help choosing the right type of care—call the  
14 Mental Health Customer Service number on your ID card.”

15 179. Again describing its “Find a doctor” tool on the homepage of its website, Blue Shield  
16 claims: “[Through] Find a Doctor[, w]e offer access to a wide range of doctors, specialists, and  
17 hospitals to help you find care wherever you live or work. Our PPO [and] HMO ... **networks are**  
18 **among the largest in California.**”

19 180. Blue Shield promises on its website that, “[n]o matter what level of behavioral health  
20 care you need, **you have inpatient and outpatient options.**”

21 181. On information and belief, Magellan’s website and publicly available marketing  
22 materials featured substantially similar statements regarding the accuracy and robustness of the mental  
23 health network.

24 182. Defendants’ representations about the size and breadth of their provider network are  
25 grossly misleading because an estimated 76–92% of those listings are “ghosts.” Defendants’ network  
26 of mental health providers available to take new patients is far smaller than advertised.

27 183. Defendants’ directory is intentionally and grossly inaccurate, and consumers are often  
28 left struggling and wasting time searching for treatment long after they started searching for a mental

1 health professional. Consumers often have to seek help from costly out-of-network providers because  
2 Defendants’ network lacks adequate available providers.

3 184. Plaintiffs’ contracts with Blue Shield—the documents that Blue Shield itself submitted  
4 in its Request for Judicial Notice, Dkt. No. 42—are replete with promises regarding the Blue Shield  
5 and Magellan provider directory.

6 185. Plaintiffs’ contracts with Blue Shield repeatedly direct members to consult Defendants’  
7 website and their directory to find in-network care.

8 186. All of Plaintiffs’ contracts instruct them to “[v]isit *blueshieldca.com* or use the Blue  
9 Shield mobile app and click on *Find a Doctor* for a list of your plan’s *Participating Providers*.” RJN  
10 Ex. 1 at 25; RJN Ex. 2 at 25; RJN Ex. 3 at 17; RJN Ex. 4 at 17; RJN Ex. 7 at 16; RJN Ex. 8 at 16; RJN  
11 Ex. 9 at 16; RJN Ex. 10 at 16.

12 187. Contract documents further state, “You can find Participating Providers in this network  
13 at blueshieldca.com.” RJN Ex. 1 at 4; RJN Ex. 2 at 4; RJN Ex. 3 at 5; RJN Ex. 4 at 5; RJN Ex. 7 at 4;  
14 RJN Ex. 8 at 4; RJN Ex. 9 at 4; RJN Ex. 10 at 4. The contracts also encourage members to “Visit  
15 blueshieldca.com and click on Find a Doctor to access the MHSA network.” RJN Ex. 1 at 67; RJN  
16 Ex. 2 at 67; RJN Ex. 3 at 59; RJN Ex. 4 at 59; Ex. 7 at 54; RJN Ex. 8 at 56; RJN Ex. 9 at 57; RJN Ex.  
17 10 at 59.

18 188. In addition, the bottom of every page of Plaintiffs’ contracts with Blue Shield includes  
19 the statement: “Questions? Visit blueshieldca.com, use the Blue Shield mobile app, or call Customer  
20 Service at 1-888-319-5999,” incorporating the online provider directory and other representations on  
21 the Blue Shield website into the contracts.

22 189. Blue Shield also instructs members who are “having difficulty obtaining services” to  
23 “call your health plan at the telephone number on the back of your health plan identification card.”  
24 RJN Ex. 1 at 130 ; RJN Ex. 2 at 132; RJN Ex. 4 at 100; RJN Ex. 10.

25 190. Further, Plaintiffs’ contracts with Blue Shield promise that the provider directory will  
26 be updated for accuracy.

27  
28

1 191. For instance, Ms. Roiz’s Evidence of Coverage states: “If a provider leaves this plan’s  
2 network, the status of the provider will change from Participating to Non-Participating.” RJN Ex. 2  
3 at 25.

4 192. On a page of its website titled “Information about the provider directory,” Blue Shield  
5 says that it “makes every attempt to validate the information in the directories.” Blue Shield claims  
6 to validate information in its directory at least once every 90 days and credential contracted providers  
7 every three years.

8 193. Magellan’s directory page for Blue Shield plans includes the date of the “Provider  
9 Directory Last Update,” which is typically within one to two business days of the current date. In  
10 truth, Defendants’ claims of regularly updating the directory are lies: Defendants’ directory reflects  
11 ghost rates over 75%.

12 194. Defendants mislead consumers by making them believe that they will have access to a  
13 sufficiently broad network of available, geographically accessible providers to meet their care needs  
14 and make use of the coverage provided by Defendants. In reality, Defendants’ directory is inaccurate  
15 and their network of available providers is sparse.

16 195. Consumers, including Plaintiffs, rely on Defendants’ directory to find providers in their  
17 health plan. As stated by the American Medical Association and the Council for Affordable Quality  
18 Healthcare:

19 Health plans are expected by their members and their contracted practices  
20 to display a provider directory to the public that represents an accurate  
21 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.<sup>42</sup>

22 196. Defendants’ repeated focus on the importance of using an in-network provider, and  
23 repeated direction to members to use the provider directory to find an in-network provider, further  
24 confirms that members can rely on the directory to accurately reflect the pool of available, in-network  
25 providers. For example, Blue Shield encourages prospective enrollees to “review the list of providers  
26 [in the] directory before enrolling in this health plan.”

27  
28 <sup>42</sup> Improving Health Plan Provider Directories, *supra* n.28, at 7.

1 197. Any argument by Defendants that the members should have themselves verified that  
2 the providers were in fact in network does not absolve Defendants of their obligation to accurately  
3 represent the mental health providers available in their network.

4 198. Any boilerplate disclaimers Defendants might provide would be woefully insufficient.  
5 Put another way, no reasonable consumer viewing a boilerplate disclaimer would understand that more  
6 than 75% of mental health providers listed in Defendants' directory are not, as promised, available to  
7 treat members of Blue Shield's plans. Indeed, there is no disclaimer broad enough to absolve that  
8 level of deception.

9 199. Defendants also misrepresent their willingness to allow members to see out-of-network  
10 providers at in-network rates when their network is not adequate to meet members' care needs.

11 200. Plaintiffs' contracts with Blue Shield contain three separate provisions requiring Blue  
12 Shield to either find timely and geographically accessible mental health care for a member or cover  
13 their care from an out-of-network provider as in network.

14 201. Plaintiffs' contracts say: "If you are unable to schedule an appointment with a  
15 Participating Provider for Mental Health and Substance Use Disorder services, contact Mental Health  
16 Customer Service. The MHSA will help you either schedule an appointment with a Participating  
17 Provider, or select a Non-Participating Provider in your area within five calendar days and contact you  
18 regarding available appointment times. For any Covered Services, you will be responsible for no more  
19 than the Cost Share for seeing a Non-Participating Provider." RJN Ex. 1 at 67; RJN Ex. 2 at 67; RJN  
20 Ex. 4 at 59; RJN Ex. 9 at 57; RJN Ex. 10 at 59.

21 202. Plaintiffs' contracts further provide: "You have a right to receive timely and  
22 geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need  
23 them. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the  
24 health plan's network, ***the health plan must cover and arrange needed services for you from an out-***  
25 ***of-network provider***. If that happens, you do not have to pay anything other than your ordinary in-  
26 network cost-sharing." RJN Ex. 1 at 129 (emphasis added); RJN Ex. 2 at 131 (emphasis added); RJN  
27 Ex. 4 at 100 (emphasis added); RJN Ex. 9 at 98 (emphasis added); RJN Ex. 10 at 103 (emphasis  
28 added). Of course, just getting care from *some* provider is the bare minimum (which Defendants still

1 failed to provide). Defendants promised, and Plaintiffs contracted for the right to receive, access to a  
2 *robust selection* of providers. Even if Defendants had provided Plaintiffs access to a single provider  
3 or small number of providers, Defendants promised, and were obligated to provide, access to the full  
4 panoply of providers listed in their directory.

5 203. Plaintiffs’ contracts continue: “If you do not need the services urgently, your health  
6 plan **must** offer an appointment for you that is no more than 10 business days from when you requested  
7 the services from the health plan. ***If you urgently need the services, your health plan must offer you***  
8 ***an appointment within 48 hours of your request*** (if the health plan does not require prior authorization  
9 for the appointment) ***or within 96 hours*** (if the health plan does require prior authorization). If your  
10 health plan does not arrange for you to receive services within these timeframes and within geographic  
11 access standards, ***you can arrange to receive services from any licensed provider, even if the provider***  
12 ***is not in your health plan’s network.***” RJN Ex. 1 at 129–30 (emphasis added); RJN Ex. 2 at 131–32  
13 (emphasis added); RJN Ex. 4 at 100 (emphasis added); RJN Ex. 9 at 98 (emphasis added) RJN Ex. 10  
14 at 103 (emphasis added).

15 204. Plaintiffs’ contracts with Blue Shield also include access standards, promising that  
16 “when you call for an appointment, you will see your provider within a reasonable timeframe.” Blue  
17 Shield’s contracts with Plaintiffs provide that an office visit with a non-physician mental health or  
18 substance use disorder provider “will occur ... [w]ithin 10 business days,” and a follow-up  
19 appointment “will occur ... [w]ithin 10 business days of the prior appointment for those undergoing a  
20 course of treatment for an ongoing mental health or substance use disorder condition.” RJN Ex. 1 at  
21 32–33; RJN Ex. 2 at 32–33; RJN Ex. 3 at 26–27; RJN Ex. 4 at 26–27; RJN Ex. 7 at 23; RJN Ex. 8 at  
22 25; RJN Ex. 9 at 25–26; RJN Ex. 10 at 27–28.

23 205. Ms. Roiz’s contracts with Blue Shield provide: “If the services cannot reasonably be  
24 obtained from a Participating Provider, ***we will approve your request and you will only be responsible***  
25 ***for the Participating Provider Cost Share.***” RJN Ex. 1 at 30 (emphasis added); RJN Ex. 2 at 30  
26 (emphasis added).

27 206. In the provider directory, Defendants misrepresent the network status of providers as  
28 well as other crucial information such as their availability to accept new patients, their contact

1 information, the services they provide, and their locations. Members and prospective members rely  
2 on these representations to understand the availability of care within Defendants' network.

3 207. Defendants actively mislead members into thinking that if an in-network provider is  
4 not available, they have no option but to forego mental health care when, in reality as discussed above,  
5 Defendants are required to cover an out-of-network provider at an in-network rate when there are no  
6 timely available and geographically accessible providers in Defendants' network.

7 208. In addition, Defendants fail to make clear to members that if an in-network provider is  
8 not available, then members may be able to use an out-of-network provider but still pay the in-network  
9 cost—that information is a contractual provision at least 30 pages into their Evidence of Coverage,  
10 which members must download from the Blue Shield website to access. Defendants do not inform  
11 members of this right in their Summary of Benefits or by phone, even when asked about this issue  
12 directly. Indeed, when Ms. Roiz and Ms. Castillo repeatedly told Magellan's representatives, who  
13 acted on Blue Shield's behalf, that providers listed in the directory as taking new patients were not  
14 actually available, the representatives lied to them that they must choose a provider in the directory.  
15

16 209. Separately and together, Defendants' representations mislead consumers to believe that  
17 members will have access to the robust network of available providers reflected in its provider  
18 directory, that the network is broad enough to allow them to easily utilize their comprehensive  
19 coverage with Defendants, and that they only need to look to and rely on the provider network to find  
20 necessary mental health care. In reality, Defendants' failure to maintain an accurate directory makes  
21 it nearly impossible to obtain in-network mental health care.  
22

23 210. The incorporation of the inaccurate directory into the plans' marketing materials  
24 through references to providers, services, and network on Defendants' public websites constituted a  
25 knowing untrue, deceptive, and misleading statement in connection with the marketing and sale of the  
26 plan.  
27  
28

1           211. In addition to the affirmative misrepresentations made by Defendants about the breadth  
2 of their provider network and comprehensiveness of Defendants’ mental health care coverage,  
3 Defendants also make material omissions, including but not limited to their failure to disclose:

- 4           a) the inadequacy of Defendants’ mental health provider network to meet members’  
5           needs;
- 6           b) the extent of provider directory inaccuracies;
- 7           c) that the vast majority of in-network mental health providers are not accessible because  
8           they are not actually taking new patients;
- 9           d) the likelihood that members will be unable to find an in-network mental health provider  
10           through the directory;
- 11           e) the likelihood that members will need to delay or forgo care, or resort to using an out-  
12           of-network provider; and
- 13           f) the likelihood that members will be unable to use the coverage that their plan provides  
14           for in-network mental health care.

15           212. There is complete information asymmetry between Defendants and consumers:  
16 Defendants have an obligation under the law to access all the relevant information, including their  
17 own contracts with in-network providers, to determine whether providers are accurately listed, and to  
18 make regular updates to ensure accuracy. On the other hand, members can only become aware of the  
19 extent of the directory inaccuracies after expending significant time and energy through trial and error,  
20 hours of calls, and extensive research, in many cases while suffering from mental health crises. The  
21 information is not readily available to Plaintiffs and other consumers.

22           **B. Defendants’ Misrepresentations and Omissions Are Material**

23           213. Plaintiffs relied on Defendants’ provider directory and representations regarding their  
24 provider network when choosing their health plans. Consumers, including Plaintiffs, rely on a health  
25 plan’s provider directory when selecting their health plan.<sup>43</sup> Consumers, including Plaintiffs, identify  
26

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27 <sup>43</sup> See Statista, *Most Important Considerations for Americans in Choosing a Plan from a Health*  
28 *Insurance Company as of 2016*, (Dec. 14, 2016) [https://www.statista.com/statistics/654828/most-  
important-considerations-for-choosing-health-insurance-plan/](https://www.statista.com/statistics/654828/most-important-considerations-for-choosing-health-insurance-plan/).

1 provider choice as one of the most important considerations when selecting a health plan.<sup>44</sup> Indeed,  
2 in a Kaiser Family Foundation survey, 60% of non-group health insurance enrollees reported that  
3 having a choice of providers was either “very important” or “extremely important” to them.<sup>45</sup> Studies  
4 show that individuals are willing to pay higher premiums for the ability to continue seeing their  
5 existing provider(s) and for a plan with a broader provider network.<sup>46</sup> Studies also show that insurance  
6 companies charge higher premiums for plans with broader provider networks—in other words,  
7 consumers are willing to pay more, and are charged more, for access to a larger network of mental  
8 health providers. Indeed, a dollar value can be assigned to each percentage increase in a plan’s  
9 provider network. By furnishing a provider network that was drastically smaller than what they  
10 promised, Defendants overcharged Plaintiffs for their health insurance coverage.

11 214. Given the importance of the provider network to prospective members, Defendants’  
12 misrepresentations and omissions in their directory would influence the decision of a reasonable  
13 consumer—and did influence Plaintiffs’ decisions—to enroll in Blue Shield’s health insurance for  
14 access to Defendants’ provider network. The provider directory and network information are  
15 disseminated by Defendants, which Plaintiffs and other consumers logically view as the authoritative  
16 source of information about their in-network providers, scope of coverage, and other plan policies.

17 215. As a result of Defendants’ misrepresentations and omissions, a reasonable consumer  
18 would understandably believe—and Plaintiffs did believe—that the providers listed in the provider  
19 directory as being in-network and available to see new patients actually were in-network with  
20 Defendants and accepting new patients. If a reasonable consumer were aware of the extent of the  
21 inaccuracies of Defendants’ directory, the sparse nature of Defendants’ provider network, and the

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22  
23 <sup>44</sup> See Blumberg et al., *Factors Influencing Health Plan Choice among the Marketplace Target*  
24 *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](https://www.urban.org/sites/default/files/2024-05/hrms_decision_factors.pdf).

25 <sup>45</sup> Hamel et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2*, Kaiser Family Foundation  
26 (May 21, 2015), <https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/> (finding a combined 60% of respondents consider choice of providers to be “extremely important” or “very important”).

27 <sup>46</sup> See, e.g., Eline M. van den Broek-Altenburg & Adam J. Atherly, *Patient Preferences for Provider*  
28 *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>.

1 consequent difficulties that members face in accessing in-network care, they would not enroll in Blue  
2 Shield’s plan. If Plaintiffs had been so aware, they would not have enrolled in Blue Shield’s plan.

3 216. Accordingly, Defendants’ misrepresentations about their mental health provider  
4 network and coverage are materially misleading to consumers.

5 **C. Members’ Reliance on Defendants’ Misrepresentations and Omissions**

6 217. Plaintiffs had a range of choices when selecting health insurance plans. For example,  
7 public employees like Claudine Castillo and Kevin Maedel are able to select from a wide range of  
8 plans from multiple insurers during their employers’ open enrollment period.

9 218. In the absence of a qualifying event like a marriage, change in employment, or birth of  
10 a child, most consumers are not eligible to change insurance plans mid-year. As a result, consumers  
11 are locked into their selected plan for a full year and do not have an opportunity to switch to a different  
12 plan if they discover mid-year that their insurance company has not accurately represented its  
13 coverage.

14 219. Even when consumers realize the extent of Defendants’ lies regarding the availability  
15 of in-network mental health care, consumers frequently develop critical relationships with in-network,  
16 non-mental-health-care providers who understand their medical needs, causing consumers to re-enroll  
17 in the plans. That was the intended, or at least foreseeable, effect of Defendants’ bait-and-switch  
18 scheme: lure people into their health insurance plan with false promises of mental health benefits, and  
19 by the time the next enrollment period comes around, they will be trapped by their (or their family  
20 members’) dependence on their existing medical providers and the difficulty of switching plans. That  
21 is what happened with Plaintiffs.

22 220. When selecting a plan, Plaintiffs relied on Defendants’ misrepresentations that  
23 members would have access to the robust network of mental health providers listed in their provider  
24 directory, that Defendants contract with an adequate network of providers to meet members’ care  
25 needs, and that Defendants maintained an accurate provider directory to enable members to locate in-  
26 network care.

27 221. These misrepresentations about the size and breadth of the mental health provider  
28 network, the ease of finding mental health treatment by using the provider directory, the freedom to

1 choose any in-network provider listed as taking new patients, the ability to control costs by seeing an  
2 in-network provider, and the comprehensive coverage of mental health care would induce a reasonable  
3 consumer—and did induce Plaintiffs—to choose the Blue Shield plans in which they enrolled.

4 222. Upon information and belief, competitors of Defendants offer health insurance plans  
5 that furnish access to robust mental health provider networks and directories that accurately represent  
6 their provider networks.

7 **D. Defendants Knew That Their Provider Directory Was Inaccurate and That Their**  
8 **Representations Regarding Their Network Were Deceptive**

9 223. At all relevant times (*i.e.*, before and throughout Plaintiff’s enrollment in Blue Shield’s  
10 health insurance), Defendants have willfully and knowingly maintained an inaccurate and inflated  
11 provider directory to induce consumers to enroll in their health insurance and to conceal their non-  
12 compliance with network adequacy standards.

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

15 225. As one state senator put it, insurance companies have “known about this for a long time  
16 and they haven’t done anything about it. It’s difficult not to assume that this kind of barrier is  
17 intentional.”<sup>47</sup> Insurance companies have been successfully sued over the issue.<sup>48</sup> Indeed, in 2015,  
18 the California Department of Managed Health Care (“DMHC”) fined Blue Shield for publishing an  
19 inaccurate provider directory.<sup>49</sup>

20 226. The sheer magnitude of the inaccuracies in Defendants’ directory—as many as 92% of  
21 the mental health providers listed—can only be the product of knowing misconduct or willful  
22 blindness, particularly in light of Defendants’ legal obligation to update and maintain the directory.

23  
24 <sup>47</sup> Turban, *supra* n.30.

25 <sup>48</sup> See, e.g., Laura Mahoney, *Anthem Resolves Calif. Provider Directory Error Case*, Bloomberg Law  
26 (Aug. 17, 2016), <https://news.bloomberglaw.com/health-law-and-business/anthem-resolves-calif-provider-directory-error-case>.

27 <sup>49</sup> See *DMHC fines Blue Shield and Anthem for provider directory inaccuracies*, California Medical  
28 Ass’n (Nov. 9, 2015), <https://www.cmadocs.org/newsroom/news/view/ArticleId/29726/DMHC-fines-Blue-Shield-and-Anthem-for-provider-directory-inaccuracies>.

1 227. As demonstrated by the secret shopper studies discussed above, Defendants published  
2 a false list of mental health providers in California. Defendants falsely listed non-existent, unavailable,  
3 out-of-network, and irrelevant providers (*i.e.*, providers who do not provide the services specified in  
4 the directory).

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

7 229. Defendants are incentivized to maintain, generate, and continue to publish an  
8 inaccurate directory to attract new enrollees, maintain current enrollees, and profit from enrollees'  
9 premiums while not actually providing the coverage that Defendants falsely represented that they  
10 provide.

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

17 **IV. Defendants Have Been Enriched and Members Have Been Injured by Defendants'  
18 Misrepresentations and Omissions**

19 231. Defendants' knowing misrepresentations about the breadth of their provider network  
20 confer significant financial benefits on Defendants and, conversely, deprive plan members of the  
21 benefit of their bargain.

22 232. Prospective plan members are more likely to enroll if they see their existing provider  
23 listed as in-network or if the list of available in-network providers is robust. Masking their inadequate  
24 network with an inaccurate provider directory therefore allows Defendants to attract more customers  
25 and charge higher premiums—all unjustly boosting Defendants' profits. Indeed, the more customers  
26 who enroll in the plans, and the more they (or their employers) pay in premiums, the more Defendants  
27 profit. Each Defendant receives a portion of the premiums for Plaintiffs', and other members', health  
28 insurance enrollment. Likewise, every time a member delays or forgoes care after failing to locate an

1 available in-network provider, Defendants evade their obligation to pay for that member's care,  
2 reducing costs (and thereby increasing profits).<sup>50</sup> Defendants also reduce costs by not having to  
3 expend resources creating and maintaining a robust provider network and an accurate provider  
4 directory, as they are statutorily and contractually required to do.

5 233. Although Blue Shield offered the health insurance plans, because Magellan served as  
6 the plans' MHSA, the more consumers enrolled in Blue Shield's plans, the more Blue Shield's profits  
7 increased, and the more Blue Shield passed on a greater portion of those profits to Magellan.  
8 Accordingly, Magellan was unjustly enriched through its and Blue Shield's lies and the resulting  
9 increase in enrollment in Blue Shield's plans.

10 234. Plaintiffs and others similarly situated have been grievously injured by Defendants'  
11 illegal conduct and the resulting inability to access necessary mental health treatment for themselves  
12 and their families.

13 235. Each percent increase in the size of an insurance plan's network equates to a measurable  
14 increase in the cost of that plan's premium.<sup>51</sup> In other words, insurance premiums increase  
15 concomitantly with network size. Consumers pay more for a larger network, since it means a greater  
16 number of providers to choose from. By offering a network that was significantly smaller than what  
17 was promised, Plaintiffs paid for important benefits that Defendants never delivered.

18 236. As a result of Defendants' illegal conduct, Plaintiffs and other class members have  
19 suffered grievous injury, including facing significant, years-long delays in receiving critical mental  
20 health care; having to pay an inflated premium for illusory benefits; having to pay exorbitant fees for  
21

22  
23 <sup>50</sup> 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>.

24 <sup>51</sup> Numerous academic studies on healthcare premiums and the size of provider networks support this  
25 principle. See, e.g., Daniel Polsky, Bingxiao Wu, *Provider Networks and Health Plan Premium  
Variation*, Health Serv. Res. (Aug. 13, 2020), <https://doi.org/10.1111/1475-6773.13447>; Coleman  
26 Drake, *What Are Consumers Willing to Pay For a Broad Network Health Plan?: Evidence from  
Covered California*, J. of Health Economics (Dec. 18, 2021),  
27 <https://doi.org/10.1016/j.jhealeco.2018.12.003>; Keith Marzilli Ericson, Amanda Starc, *Measuring  
Consumer Valuation of Limited Provider Networks*, Am. Econ. Rev. (May 2015),  
28 <https://doi.org/10.1257/aer.p20151082>.

1 out-of-network care for themselves and their dependents; and being unable to find appropriate  
2 treatment or, alarmingly, any treatment at all.

3 237. Defendants’ misrepresentations and omissions are the direct and proximate causes of  
4 the harms Plaintiffs have endured. Had Defendants accurately represented their mental health care  
5 coverage, Plaintiffs—and countless other consumers—would not have enrolled in coverage with  
6 Defendants. By enrolling in one of the other health insurance plans available to them, Plaintiffs would  
7 have had access to the care they were promised, paid lower premiums, and/or saved thousands of  
8 dollars in out-of-pocket expenses—not to mention the countless hours and emotional expense they  
9 would have saved.

10 238. Moreover, Defendants’ misrepresentations artificially inflated the market price of their  
11 product, causing Plaintiffs to pay more than they otherwise would have for premiums. As a direct and  
12 proximate result of Defendants’ unfair and deceptive acts and practices, Plaintiffs suffered injury by  
13 paying insurance premiums but failing to receive commensurate benefits.

14 **CLASS ACTION ALLEGATIONS**

15 239. This action is brought by Plaintiffs individually and on behalf of a class (the “Class”)  
16 pursuant to Federal Rule of Civil Procedure 23. The Class includes all those who have purchased or  
17 enrolled in a Blue Shield plan in California at any point from November 19, 2021, through the date of  
18 class certification.

19 240. Plaintiffs also seek certification of the following three Sub-Classes:

20 **A.** All Class members who are currently, or were previously, enrolled in any of Blue  
21 Shield’s non-ERISA Plans in California at any point from four years prior to the  
22 filing of the Complaint through the date of class certification.

23 **B.** All Class members who are currently, or were previously, enrolled in any of Blue  
24 Shield’s ERISA Plans in California at any point from November 19, 2021, through  
25 the date of class certification.

26 **C.** All Class members who, during the class period, paid for out-of-network care from  
27 a provider listed as in-network on Defendants’ provider directory or paid for out-  
28

1 of-network care when there was no available in-network provider with similar  
2 qualifications within a reasonable distance.

3 241. Excluded from the Class are Defendants’ officers, directors, employees,  
4 co-conspirators, and legal representatives, and any judge, justice, or judicial officer to whom the  
5 litigation is assigned.

6 242. Plaintiffs reserve the right to amend or modify the Class and Sub-Class definitions.

7 243. **Numerosity.** The Class as a whole and each of the three Sub-Classes consist of  
8 thousands of individuals and entities, and is thus so numerous that joinder of all members is  
9 impracticable. The exact number and identity of Class members is unknown to Plaintiffs at this time  
10 but can be ascertained through appropriate discovery.

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

- 14 a) whether Defendants breached their contractual obligations by failing to provide the promised  
15 network of providers and/or by failing to comply with ERISA, the No Surprises Act, the  
16 MHPAEA, and/or other statutes, regulations, and rules with which Defendants are  
17 contractually obligated to comply;
- 18 b) whether Defendants’ representations and/or omissions with respect to the plan were false or  
19 misleading under ERISA, California Insurance Code Section 790, California Business &  
20 Professions Code Section 17500, California Business & Professions Code Section  
21 17200, and/or common law;
- 22 c) whether Defendants’ violations of law were willful and knowing;
- 23 d) whether Defendants’ mental health provider directory was inaccurate and/or inadequate;
- 24 e) whether Defendants failed to disclose to members and prospective members that the provider  
25 directory was inaccurate and/or inadequate;
- 26 f) whether a reasonable consumer would be misled by Defendants’ acts and practices;
- 27 g) whether Plaintiffs and Class members are entitled to receive specific types of relief such as  
28 actual damages, and the methodology for calculating those damages;

- 1 h) whether Plaintiffs and Class members conferred a benefit on Defendants through enrollment
- 2 in Blue Shield’s plans, payment of premiums, and not utilizing in-network providers or
- 3 otherwise not obtaining mental health care, which profits were passed on to Magellan as the
- 4 plans’ designated MHSA; and
- 5 i) whether equity and good conscience require restitution to Plaintiffs and Class members
- 6 and/or the establishment of a constructive trust, and the amount of such restitution or
- 7 constructive trust.

8 245. **Typicality.** The claims asserted by Plaintiffs are typical of the claims of the Class. At  
9 all relevant times, Defendants’ provider network was inadequate and their directory inaccurate, and  
10 all Class members’ claims arise out of this common source of misrepresentations and omissions.  
11 Plaintiffs, like all Class members, were subject to deceptive and misleading representations and  
12 omissions found in Defendants’ provider directory and other marketing and plan documents regarding  
13 the comprehensiveness of mental health coverage and the provider network. Plaintiffs’ interests  
14 coincide with, and are not antagonistic to, those of the other Class members, and Plaintiffs and other  
15 Class members have been damaged by the same wrongdoing set forth in this Amended Complaint.

16 246. **Adequacy of representation.** Plaintiffs will fairly and adequately protect the interests  
17 of the Class and do not have any interests antagonistic to those of the Class members. Plaintiffs have  
18 retained counsel competent and experienced in class actions and health insurance and consumer  
19 protection litigation, who are competent to serve as Class counsel. Plaintiffs and their counsel will  
20 fairly and adequately protect the interests of the Class members.

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

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

- 1 b) the prosecution of thousands of separate actions by individual members would risk
- 2 inconsistency in adjudication and outcomes that would establish incompatible standards of
- 3 conduct for Defendants and burden the courts;
- 4 c) when Defendants' liability has been adjudicated, claims of all Class members can be
- 5 determined by the Court;
- 6 d) this action will cause an orderly and expeditious administration of the Class claims and
- 7 foster economies of time, effort, and expense, and ensure uniformity of decisions;
- 8 e) without a class action, many Class members would continue to suffer injury while
- 9 Defendants retain the substantial proceeds of their wrongful conduct; and
- 10 f) this action does not present any undue difficulties that would impede its management
- 11 by the Court as a class action.

12 248. **Ascertainability.** The identities and addresses of Class members can be readily  
13 ascertained from business records maintained by Defendants, and/or self-authentication. The precise  
14 number of Class members, and their addresses, can be ascertained from Defendants' records. Plaintiffs  
15 anticipate providing appropriate notice to the Class to be approved by the Court after class  
16 certification, or pursuant to court order.

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

19 **FIRST CAUSE OF ACTION**

20 **Breach of Contract – Blue Shield**

21 **(On behalf of Plaintiffs and Class members who purchased or enrolled in a non-ERISA plan)**

22 250. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
23 restate them as if fully set forth herein.

24 251. Blue Shield and Plaintiffs have a direct contractual relationship. The terms of that  
25 direct contractual relationship are governed by the insurance materials provided by Defendants.

26 252. Blue Shield has breached the contracts by failing to contract with a sufficient number  
27 of mental health providers to allow members to access timely in-network mental health services and  
28 failing to provide an accurate provider directory.

1           253. In Blue Shield’s contracts with each enrollee, Defendants agree to provide coverage  
2 for in-network mental health care, to assist members in accessing geographically accessible in-network  
3 care via their directory, and to cover out-of-network services at the in-network rate when in-network  
4 care is not available and accessible to members.

5           254. Blue Shield plan documents—which are contract documents—direct members to  
6 “[v]isit blueshieldca.com and click on Find a Doctor to access the MHSA Participating Provider  
7 network.” RJN Ex. 3 at 59; RJN Ex. 4 at 59; RJN Ex. 7 at 53; RJN Ex. 8 at 56; RJN Ex. 9 at 57; RJN  
8 Ex. 10 at 59. Plan documents further state, “You can find Participating Providers in this network at  
9 blueshieldca.com.” RJN Ex. 3 at 5; RJN Ex. 4 at 5; RJN Ex. 7 at 4; RJN Ex. 8 at 4; RJN Ex. 9 at 4;  
10 RJN Ex. 10 at 4. The plan documents also direct enrollees to “[v]isit blueshieldca.com or use the Blue  
11 Shield mobile app to ... [f]ind a doctor or other Health Care Provider.” RJN Ex. 3 at 12–13; RJN Ex.  
12 4 at 13; RJN at Ex. 7 at 12; RJN Ex. 8 at 12; RJN Ex. 9 at 12; RJN Ex. 10 at 12; *see also* RJN Ex. 3 at  
13 17 (“Visit blueshieldca.com or use the Blue Shield mobile app and click on **Find a Doctor** for a list  
14 of plan’s **Participating Providers**.” (emphasis in original)); RJN Ex. 4 at 17 (same); RJN Ex. 7 at 16  
15 (same); RJN Ex. 8 at 16 (same); RJN Ex. 9 at 16 (same); RJN Ex. 10 at 16 (same). Each page of Blue  
16 Shield plan documents refers members with questions to “[v]isit blueshieldca.com,” thus incorporating  
17 the online directory by reference. RJN Ex. 3; RJN Ex. 4; RJN Ex. 7; RJN Ex. 8; RJN Ex. 9; RJN Ex.  
18 10. Contrary to Blue Shield’s contractual representations, its online directory does not accurately  
19 reflect its provider network and members (like Plaintiffs) cannot use the directory to reliably find  
20 available, in-network providers to treat them. As a result, Plaintiffs and other members have been  
21 unable to access the mental health benefits they were contractually promised.

22           255. As Blue Shield’s plan documents explicitly direct members to its website, the contracts  
23 incorporate the Blue Shield website by reference. On a web page titled “Blue Shield’s network,” Blue  
24 Shield says that “[o]ur network of doctors and hospitals is designed to meet the needs of  
25 members .... A full selection of behavioral health providers for mental health care and substance use  
26 treatment are available. Additional specialists are included in our network if they meet our  
27 credentialing requirements to help make sure members have access to a larger number of doctors  
28 within a reasonable distance from home.” This page then directs the user to Blue Shield’s directory

1 page to “Find a doctor.” As explained in detail above, Blue Shield failed to comply with these  
2 contractual commitments. Blue Shield has not made “available” to Plaintiffs and other members a  
3 “full selection of behavioral health providers for mental health care and substance use treatment.”

4 256. Blue Shield repeatedly directs members seeking mental health care to its “Find a  
5 doctor” tool and to call Blue Shield for assistance: “If you need help finding behavioral health support,  
6 Find a doctor can help you search for in-network providers covered by your benefit plan. If you can’t  
7 find the provider or service you’re looking for—or want help choosing the right type of care—call the  
8 Mental Health Customer Service number on your ID card.”

9 257. Again describing its “Find a doctor” tool on the homepage of its website, Blue Shield  
10 claims: “[Through] Find a Doctor[, w]e offer access to a wide range of doctors, specialists, and  
11 hospitals to help you find care wherever you live or work. Our PPO [and] HMO ... **networks are**  
12 **among the largest in California.**” That is false. As explained in detail above, Blue Shield’s network  
13 of mental and behavioral health providers is virtually non-existent, contrary to its contractual  
14 representations.

15 258. Blue Shield promises on its website that, “[n]o matter what level of behavioral health  
16 care you need, **you have inpatient and outpatient options.**” That is false. As explained in detail  
17 above, Blue Shield has failed to provide Plaintiffs the behavioral health care they needed and to which  
18 they were entitled, in breach of its contractual obligations.

19 259. Blue Shield plan documents say: “If you are unable to schedule an appointment with a  
20 Participating Provider for Mental Health and Substance Use Disorder services, contact Mental Health  
21 Customer Service. The MHSA will help you either schedule an appointment with a Participating  
22 Provider, or select a Non-Participating Provider in your area within five calendar days and contact you  
23 regarding available appointment times. For any Covered Services, you will be responsible for no more  
24 than the Cost Share for seeing a Non-Participating Provider.” RJN Ex. 4 at 59; RJN Ex. 9 at 57; RJN  
25 Ex. 10 at 59. As explained in detail above, Blue Shield failed to comply with these contractual  
26 commitments.

27 260. The contracts further provide: “You have a right to receive timely and geographically  
28 accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Blue

1 Shield fails to arrange those services for you with an appropriate provider who is in the health plan’s  
2 network, ***the health plan must cover and arrange needed services for you from an out-of-network***  
3 ***provider***. If that happens, you do not have to pay anything other than your ordinary in-network cost-  
4 sharing.” RJN Ex. 4 at 100 (emphasis added); RJN Ex. 9 at 98 (emphasis added); RJN Ex. 10 at 103  
5 (emphasis added). As explained in detail above, Blue Shield failed to comply with these contractual  
6 commitments.

7 261. The contracts continue: “If you do not need the services urgently, your health plan ***must***  
8 offer an appointment for you that is no more than 10 business days from when you requested the  
9 services from the health plan. ***If you urgently need the services, your health plan must offer you an***  
10 ***appointment within 48 hours of your request*** (if the health plan does not require prior authorization  
11 for the appointment) ***or within 96 hours*** (if the health plan does require prior authorization).” RJN  
12 Ex. 4 at 100 (emphasis added); RJN Ex. 9 at 98 (emphasis added); RJN Ex. 10 at 103 (emphasis  
13 added). As explained in detail above, Blue Shield failed to comply with these contractual  
14 commitments.

15 262. The contracts also include access standards, promising that “when you call for an  
16 appointment, you will see your provider within a reasonable timeframe.” Blue Shield’s contracts with  
17 Plaintiffs provide that an office visit with a non-physician mental health or substance use disorder  
18 provider “will occur ... [w]ithin 10 business days,” and a follow-up appointment “will  
19 occur ... [w]ithin 10 business days of the prior appointment for those undergoing a course of treatment  
20 for an ongoing mental health or substance use disorder condition.” RJN Ex. 3 at 26–27; RJN Ex. 4 at  
21 26–27; RJN Ex. 7 at 23; RJN Ex. 8 at 25; RJN Ex. 9 at 25–26; RJN Ex. 10 at 27–28. As explained in  
22 detail above, Blue Shield failed to comply with these contractual commitments.

23 263. Blue Shield breached its contracts with Plaintiffs by failing to provide meaningful  
24 coverage for mental health services and by failing to update and convey accurate information about  
25 the providers listed in the directory. Because Blue Shield does not maintain an accurate provider  
26 directory and does not contract with an adequate network of mental health care providers, it has been  
27 impossible for Plaintiffs to locate in-network care and therefore make use of the coverage to which  
28 they were contractually entitled.



1           268. Plaintiffs, as public employees receiving health insurance through their employment,  
2 are intended third-party beneficiaries of these contracts between the employers and Blue Shield. The  
3 employers' and Blue Shield's motivating purpose of entering these contracts was to benefit Plaintiffs  
4 through the provision of health insurance, and Plaintiffs would in fact benefit from the contracts.

5           269. Plan members, *i.e.*, Plaintiffs and the Class members, are mentioned throughout the  
6 Contracts.

7           270. Plaintiffs are likely to benefit from the performance promised in the contracts between  
8 Blue Shield and Plaintiffs' employers, since those contracts require Blue Shield to provide Plaintiffs  
9 with an accurate directory and adequate network of mental health providers.

10           271. Allowing a breach of contract action against Blue Shield is consistent with the  
11 objectives of the contracts between Blue Shield and Plaintiffs' employers and the reasonable  
12 expectations of the parties, since the contracts required Blue Shield to provide Plaintiffs with  
13 benefits—an accurate mental health provider directory, the administration of mental health benefits in  
14 compliance with federal and state laws, and an adequately broad network of accessible mental health  
15 providers—which Blue Shield failed to deliver.

16           272. Blue Shield's contracts with Plaintiffs' employers explicitly require it to comply with  
17 all "applicable state and federal statutes and regulations," including, *inter alia*, the Knox-Keene Act;  
18 Section 10133.15 of the California Insurance Code; California Health & Safety Code § 1374.72;  
19 Chapter 2.2 of Division 2 of the California Health and Safety Code; Title 28 and Chapter 10 of the  
20 California Code of Regulations; the Affordable Care Act; sections 2799A-1, 2799A-2, 2799A-3,  
21 2799A-4, 2799A-5, 2799A-7, and 2799A-8 of the Public Health Service Act; sections 716, 717,  
22 718, 719, 720, 722, and 723 of ERISA; and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823  
23 of the Internal Revenue Code of 1986. As explained above, Blue Shield has violated numerous state  
24 and federal statutes and regulations and, by extension, its contractual obligations

25  
26           273. Blue Shield has violated state and federal statutes and regulations—and therefore  
27 breached the contracts—by, among other things, failing to provide an accurate, and regularly updated,  
28 provider directory. As explained in detail above, state and federal laws require Blue Shield to provide

1 an accurate, and regularly updated, provider directory. Sections 2799A-5 of the Public Health Service  
2 Act, 720 of ERISA, and 9820 of the Internal Revenue Code of 1986 require health insurers to verify  
3 and update their provider directories not less frequently than once every 90 days, remove a provider  
4 from the directory when they are unable to verify the directory information for that provider, and  
5 update the directory within two days of receiving new information from a provider. California state  
6 laws, including Section 10133.15 of the California Insurance Code and Section 1367.27 of the Knox-  
7 Keene Act, impose similar requirements. Blue Shield’s consistent failure to maintain an accurate  
8 directory of in-network providers violates these state and federal laws and constitutes a breach of  
9 contract.

10 274. Blue Shield has also violated state and federal statutes and regulations—and therefore  
11 breached the contracts—by, among other things, failing to provide an adequate mental health provider  
12 network. As explained in detail above, state and federal laws—including the Affordable Care Act, the  
13 MHPAEA, Section 10133.54 of the California Insurance Code, Section 1367.03 of the Knox-Keene  
14 Act, and Section 2240.01 of Chapter 10 of the California Code of Regulations—require Blue Shield  
15 to provide an adequate mental health provider network. Blue Shield’s consistent failure to maintain  
16 an adequate mental health provider network violates these state and federal laws and constitutes a  
17 breach of contract.

18 275. Blue Shield has also violated state and federal statutes and regulations—and therefore  
19 breached the contracts—by providing mental health and substance use disorder benefits on less  
20 favorable terms than medical and surgical benefits. The MHPAE, 42 U.S.C. § 300gg-26, incorporated  
21 into the Affordable Care Act via 45 C.F.R. § 156.115, provides that mental health and substance use  
22 disorder benefits must not be provided on less favorable terms than medical and surgical benefits,  
23 specifically with respect to annual, aggregate, or lifetime limits on coverage, financial requirements,  
24 treatment limitations, and out-of-network coverage.<sup>52</sup> MHPAEA regulations provide that “all plan  
25 standards that limit the scope or duration of benefits for services are subject to the nonquantitative  
26 treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-

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<sup>52</sup> 29 U.S.C. §1185a(a); 42 U.S.C. § 300gg-26(a).

1 type limits, and network adequacy.”<sup>53</sup> Similarly, California Health & Safety Code § 1374.72 requires  
2 that “[e]very health care service plan” that “provides hospital, medical, or surgical coverage shall  
3 provide coverage for medically necessary treatment of mental health and substance use disorders,  
4 under the same terms and conditions applied to other medical conditions.”

5 276. Blue Shield, in administering plans that provide both medical and surgical benefits and  
6 mental health benefits, included financial requirements and treatment limitations applicable to mental  
7 health benefits that were more restrictive than those applied to substantially all medical and surgical  
8 benefits covered by the plan.

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

17 278. In sum, Blue Shield has violated state and federal laws (and, by extension, its  
18 contractual obligations to Plaintiffs and the Class) by, among other things: failing to ensure mental  
19 health network adequacy; failing to create and maintain an accurate provider directory; failing to  
20 regularly verify the accuracy of its provider network within the statutorily required timeframe, validate  
21 participation by individual providers, and remove providers from the directory who could not be  
22 verified; and providing mental health and substance use disorder benefits on less favorable terms than  
23 medical and surgical benefits.

24 279. These breaches have directly and proximately caused Plaintiffs and Class members  
25 significant harm, including monetary and non-monetary losses. Among other injuries, Blue Shield’s  
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27 <sup>53</sup> Ctrs. for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (last  
28 modified Mar. 13, 2026), <https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity>; see also 29 C.F.R. 2590.712(c)(4).

1 breaches have caused millions of dollars in damages; denied Plaintiffs the benefits to which they were  
2 entitled under their health plans and for which they paid premiums (most notably, coverage for in-  
3 network mental health care and access to the supposedly broad network of available providers); forced  
4 Plaintiffs and Class members to delay and/or forgo crucial and necessary mental health care; caused  
5 Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused  
6 Plaintiffs and Class members to incur significant out-of-pocket expenses for out-of-network provider  
7 payments, which greatly exceed the costs Plaintiffs would have incurred for the same services from  
8 in-network providers; caused Plaintiffs and Class members to reduce spending on necessities and other  
9 life costs; induced Plaintiffs and Class members to enroll in Blue Shield' plan instead of better and/or  
10 cheaper plans; prevented Plaintiffs and Class members from making informed financial and health  
11 care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological  
12 distress due to the unsuccessful provider search and their inability to receive treatment for themselves  
13 and their loved ones.

14 **THIRD CAUSE OF ACTION**

15 **Breach of Contract – Magellan**

16 **(On behalf of Plaintiffs and Class members who purchased or enrolled in a non-ERISA plan)**

17 280. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
18 restate them as if fully set forth herein.

19 281. Upon information and belief, Plaintiffs and Class Members are intended third-party  
20 beneficiaries of contracts entered into between Blue Shield and Magellan.

21 282. Upon further information and belief, these contracts require that Magellan take  
22 appropriate steps to ensure that the mental health provider directory published and disseminated by it  
23 contains accurate information and that Magellan administers mental health benefits for Blue Shield  
24 insureds in a manner that complies with applicable federal and state law.

25 283. Upon further information and belief, Plaintiffs would benefit from the performance  
26 promised in the contracts between Blue Shield and Magellan, since those contracts require Magellan  
27 to provide Plaintiffs with an accurate directory of mental health providers.  
28

1 284. Blue Shield’s and Magellan’s motivating purpose in entering these contracts was to  
2 give Plaintiffs and Class Members the benefit of the performance promised in the contracts.

3 285. Allowing a breach of contract action against Magellan is consistent with the objectives  
4 of the contracts between Blue Shield and Magellan and the reasonable expectations of the parties since  
5 the contracts required Magellan to provide Plaintiffs with benefits—an accurate mental health provider  
6 directory, the administration of their mental health benefits in compliance with the law, and an  
7 adequately broad network of accessible mental health providers—which it failed to deliver.

8 286. On information and belief, Blue Shield’s contracts with Magellan require it to comply  
9 with all applicable state and federal statutes and regulations, including, *inter alia*, the Knox-Keene  
10 Act; Section 10133.15 of the California Insurance Code; Chapter 2.2 of Division 2 of the California  
11 Health and Safety Code; Title 28 and Chapter 10 of the California Code of Regulations; the Affordable  
12 Care Act; sections 2799A–1, 2799A–2, 2799A–3, 2799A–4, 2799A–5, 2799A–7, and 2799A–8 of the  
13 Public Health Service Act; sections 716, 717, 718, 719, 720, 722, and 723 of ERISA; and sections  
14 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986. As explained  
15 above, Magellan violated numerous state and federal statutes and regulations and, by extension, its  
16 contractual obligations.

17 287. Magellan has violated state and federal statutes and regulations—and therefore  
18 breached the contracts—by, among other things, failing to provide an accurate provider directory and  
19 adequate mental health provider network.

20 288. Magellan breached the contracts by failing to contract with a sufficient number of  
21 mental health providers to allow members to access timely in-network mental health services, and by  
22 failing to provide an accurate directory.

23 289. Sections 2799A-5 of the Public Health Service Act, 720 of ERISA, and 9820 of the  
24 Internal Revenue Code of 1986 require health insurers to verify and update their provider directories  
25 not less frequently than once every 90 days, remove a provider from the directory when they are unable  
26 to verify the directory information for that provider, and update the directory within two days of  
27 receiving new information from a provider.

28

1 290. Magellan’s failure to maintain an accurate directory of in-network providers violates  
2 the requirements in ERISA and the Internal Revenue Code, and was thus a breach of its contract with  
3 Blue Shield.

4 291. Magellan has violated the above laws (and, by extension, its contractual obligations to  
5 Plaintiffs and the Class) by, among other things, failing to ensure mental health network adequacy;  
6 failing to create and maintain an adequate network of providers and an accurate provider directory;  
7 and failing to regularly verify the accuracy of its provider network within the statutorily required  
8 timeframe, validate participation by individual providers, and remove providers from the directory  
9 who could not be verified.

10 292. These breaches have directly and proximately caused Plaintiffs and Class members  
11 significant harm, including monetary and non-monetary losses. Among other injuries, Magellan’s  
12 breaches have caused millions of dollars in damages; denied Plaintiffs the benefits to which they were  
13 entitled under their health plans and for which they paid premiums (most notably, coverage for in-  
14 network mental health care and access to the supposedly broad network of available providers); forced  
15 Plaintiffs and Class members to delay and/or forgo crucial and necessary mental health care; caused  
16 Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused  
17 Plaintiffs and Class members to incur significant out-of-pocket expenses for out-of-network provider  
18 payments, which greatly exceed the costs Plaintiffs would have incurred for the same services from  
19 in-network providers; caused Plaintiffs and Class members to reduce spending on necessities and other  
20 life costs; induced Plaintiffs and Class members to enroll in Blue Shield’ plan instead of better and/or  
21 cheaper plans; prevented Plaintiffs and Class members from making informed financial and health  
22 care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological  
23 distress due to the unsuccessful provider search and their inability to receive treatment for themselves  
24 and their loved ones.

25 **FOURTH CAUSE OF ACTION**

26 **Breach of the Implied Covenant of Good Faith and Fair Dealing - Blue Shield**

27 **(On behalf of Plaintiffs and Class members who purchased or enrolled in a non-ERISA plan)**

28

1           293. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
2 restate them as if fully set forth herein.

3           294. Plaintiffs and Blue Shield have a direct contractual relationship.

4           295. Blue Shield’s contracts with Plaintiffs include an implied covenant that Blue Shield  
5 will act in good faith and deal fairly with Plaintiffs.

6           296. Plaintiffs satisfied their contractual obligations. All conditions required for Blue  
7 Shield’s full performance of its contractual obligations were met.

8           297. Blue Shield materially breached the implied covenant in several respects, including but  
9 not limited to the following:

- 10           a) Blue Shield has failed to make a good-faith effort to maintain an accurate and updated  
11 provider directory;
- 12           b) Blue Shield has failed to maintain, and failed to make a good-faith effort to maintain,  
13 an adequate network of providers;
- 14           c) Blue Shield has presented providers as being in-network and available to see new  
15 patients that were not, in fact, in-network and available to see new patients;
- 16           d) Blue Shield has failed to support Plaintiffs in locating accessible, in-network care,  
17 including by
- 18               i. purposefully making the customer service line difficult to access, requiring  
19 Plaintiffs to spend multiple hours over multiple days attempting to reach  
20 customer service representatives, despite Plaintiffs’ contracts explicitly  
21 directing them to call customer service when they have questions about their  
22 plans;
- 23               ii. intentionally failing to train and supervise customer service representatives as  
24 to the remedial steps that Plaintiffs are contractually entitled to take in the event  
25 that Plaintiffs cannot locate a geographically accessible and available in-  
26 network provider, resulting in customer service representatives falsely  
27 informing Plaintiffs that they had no recourse but to select a provider from the  
28

1 inaccurate directory, despite Plaintiffs' contracts explicitly directing them to  
2 call customer service when they have questions about their plans; and

3 iii. intentionally obscuring that Plaintiffs have the contractual right to use an out-  
4 of-network provider at an in-network cost when no in-network provider is  
5 available by failing to include this provision in Plaintiffs' Summary of Benefits,  
6 instead burying the provision at least 30 pages within 100-plus-page contracts  
7 that Plaintiffs must download from the Blue Shield website to access;

8 e) Blue Shield has required Plaintiffs to pay out-of-network rates for care that was  
9 required to be covered at in-network rates due to deficiencies in Defendants' network;  
10 and

11 f) Blue Shield has denied claims and/or failed to pay claims for providers that were listed  
12 as in-network in the directory.

13 298. By engaging in the above-listed activities, Blue Shield did not act fairly or in good  
14 faith.

15 299. Blue Shield's breaches were conscious and deliberate acts, which were designed to and  
16 did unfairly frustrate the agreed common purposes of the contracts and which disappointed Plaintiffs'  
17 and the Class's reasonable expectations by denying Plaintiffs and the Class the benefits of the contract.

18 300. Blue Shield purposefully undertook such acts to deny Plaintiffs the benefits of the  
19 contracts, thus enriching Blue Shield and permitting Blue Shield to conceal that it was violating  
20 applicable federal and state laws.

21 301. These misrepresentations have directly and proximately caused Plaintiffs and Class  
22 members significant harm, including monetary and non-monetary losses. Among other injuries, Blue  
23 Shield's misrepresentations have caused millions of dollars in damages; denied Plaintiffs the benefits  
24 to which they were entitled under their health plans and for which they paid premiums (most notably,  
25 coverage for in-network mental health care and access to the supposedly broad network of available  
26 providers); forced Plaintiffs and Class members to delay and/or forgo crucial and necessary mental  
27 health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless  
28 product; caused Plaintiffs and Class members to incur significant out-of-pocket expenses for

1 out-of-network provider payments, which greatly exceed the costs Plaintiffs would have incurred for  
2 the same services from in-network providers; caused Plaintiffs and Class members to reduce spending  
3 on necessities and other life costs; induced Plaintiffs and Class members to enroll in Blue Shield’s  
4 plan instead of better and/or cheaper plans; prevented Plaintiffs and Class members from making  
5 informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe  
6 emotional and psychological distress due to the unsuccessful provider search and their inability to  
7 receive treatment for themselves and their loved ones.

8 **FIFTH CAUSE OF ACTION**

9 **Breach of the Implied Covenant of Good Faith and Fair Dealing – Blue Shield**

10 **(On behalf of Plaintiffs and Class members who are public employees and purchased or**  
11 **enrolled in a non-ERISA plan through their employer)**

12 302. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
13 restate them as if fully set forth herein.

14 303. A contract exists between Plaintiffs’ employers and Blue Shield to provide health  
15 insurance benefits, including mental health benefits, to public employees.

16 304. Plaintiffs, as public employees receiving health insurance through their employment,  
17 are intended third-party beneficiaries of these contracts between the employers and Blue Shield. A  
18 motivating purpose of the employers and Blue Shield entering these contracts was for Plaintiffs to  
19 benefit from their contracts, and Plaintiffs would in fact benefit from the contracts.

20 305. Plan members, *i.e.*, Plaintiffs and the Class members, are mentioned throughout the  
21 contracts.

22 306. The contracts include an implied covenant that Blue Shield will act in good faith and  
23 deal fairly with Plaintiffs.

24 307. All conditions required for Blue Shield’s full performance of the contracts were met.

25 308. Blue Shield materially breached the implied covenant in several respects, including but  
26 not limited to the following:

- 27 a) Blue Shield has failed to make a good-faith effort to maintain an accurate and updated  
28 provider directory;

- 1           b) Blue Shield has failed to maintain, and failed to make a good-faith effort to maintain,  
2           an adequate network of providers;
- 3           c) Blue Shield has presented providers as being in-network and available to see new  
4           patients that were not, in fact, in-network and available to see new patients;
- 5           d) Blue Shield has failed to support Plaintiffs in locating accessible, in-network care,  
6           including by
- 7                i. purposefully making the customer service line difficult to access, requiring  
8                Plaintiffs to spend multiple hours over multiple days attempting to reach  
9                customer service representatives, despite Plaintiffs’ contracts explicitly  
10              directing them to call customer service when they have questions about their  
11              plans;
- 12              ii. intentionally failing to train and supervise customer service representatives as  
13              to the remedial steps that Plaintiffs are contractually entitled to take in the event  
14              that Plaintiffs cannot locate a geographically accessible and available in-  
15              network provider, resulting in customer service representatives falsely  
16              informing Plaintiffs that they had no recourse but to select a provider from the  
17              inaccurate directory, despite Plaintiffs’ contracts explicitly directing them to  
18              call customer service when they have questions about their plans; and
- 19              iii. intentionally obscuring that Plaintiffs have the contractual right to use an out-  
20              of-network provider at an in-network cost when no in-network provider is  
21              available by failing to include this provision in Plaintiffs’ Summary of Benefits,  
22              instead burying the provision at least 30 pages within 100-plus-page contracts  
23              that Plaintiffs must download from the Blue Shield website to access;
- 24           e) Blue Shield has required Plaintiffs to pay out-of-network rates for care that was  
25           required to be covered at in-network rates due to deficiencies in Defendants’ network;  
26           and
- 27           f) Blue Shield has denied claims and/or failed to pay claims for providers that were listed  
28           as in-network in the directory.

1 309. By engaging in the above-listed activities, Blue Shield did not act fairly or in good  
2 faith.

3 310. Blue Shield’s breaches were conscious and deliberate acts, which were designed to and  
4 did unfairly frustrate the agreed common purposes of the contract and which disappointed Plaintiffs’  
5 and the Class’s reasonable expectations by denying Plaintiffs and the Class the benefits of the  
6 contracts.

7 311. Blue Shield purposefully undertook such acts to deny Plaintiffs the benefits of the  
8 contracts, thus enriching Blue Shield and permitting Blue Shield to conceal that it was violating  
9 applicable federal and state laws.

10 312. These misrepresentations have directly and proximately caused Plaintiffs and Class  
11 members significant harm, including monetary and non-monetary losses. Among other injuries, Blue  
12 Shield’s misrepresentations have caused millions of dollars in damages; denied Plaintiffs the benefits  
13 to which they were entitled under their health plans and for which they paid premiums (most notably,  
14 coverage for in-network mental health care and access to the supposedly broad network of available  
15 providers); forced Plaintiffs and Class members to delay and/or forgo crucial and necessary mental  
16 health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless  
17 product; caused Plaintiffs and Class members to incur significant out-of-pocket expenses for  
18 out-of-network provider payments, which greatly exceed the costs Plaintiffs would have incurred for  
19 the same services from in-network providers; caused Plaintiffs and Class members to reduce spending  
20 on necessities and other life costs; induced Plaintiffs and Class members to enroll in Blue Shield’s  
21 plan instead of better and/or cheaper plans; prevented Plaintiffs and Class members from making  
22 informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe  
23 emotional and psychological distress due to the unsuccessful provider search and their inability to  
24 receive treatment for themselves and their loved ones.

25 **SIXTH CAUSE OF ACTION**

26 **Breach of the Implied Covenant of Good Faith and Fair Dealing - Magellan**

27 **(On behalf of Plaintiffs and Class members who purchased or enrolled in a non-ERISA plan)**

1           313. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
2 restate them as if fully set forth herein.

3           314. Plaintiffs are the intended third-party beneficiaries of Blue Shield’s contract with  
4 Magellan. Blue Shield’s and Magellan’s motivating purpose in entering the contract was to benefit  
5 Plaintiffs by providing them with an accessible provider network reflected in an accurate and regularly  
6 updated provider directory.

7           315. The contract includes an implied covenant that Magellan will act in good faith and deal  
8 fairly with Plaintiffs.

9           316. All conditions required for Magellan’s full performance of the contract were met.

10           317. Magellan materially breached the implied covenant in several respects, including but  
11 not limited to the following:

- 12           a) Magellan has failed to make a good-faith effort to maintain an accurate and updated  
13 provider directory;
- 14           b) Magellan has failed to maintain, and failed to make a good-faith effort to maintain, an  
15 adequate network of providers;
- 16           c) Magellan has presented providers as being in-network and available to see new patients  
17 that were not, in fact, in-network and available to see new patients;
- 18           d) Magellan has failed to support Plaintiffs in locating accessible, in-network care,  
19 including by
  - 20           i. purposefully making the customer service line difficult to access, requiring  
21 Plaintiffs to spend multiple hours over multiple days attempting to reach  
22 customer service representatives, despite Plaintiffs’ contracts explicitly  
23 directing them to call customer service when they have questions about their  
24 plans; and
  - 25           ii. intentionally failing to train and supervise customer service representatives as  
26 to the remedial steps that Plaintiffs are contractually entitled to take in the event  
27 that Plaintiffs cannot locate a geographically accessible and available in-  
28 network provider, resulting in customer service representatives falsely

1 informing Plaintiffs that they had no recourse but to select a provider from the  
2 inaccurate directory, despite Plaintiffs' contracts explicitly directing them to  
3 call customer service when they have questions about their plans;

4 e) Magellan has required Plaintiffs to pay out-of-network rates for care that was required  
5 to be covered at in-network rates due to deficiencies in Defendants' network; and

6 f) Magellan has denied claims and/or failed to pay claims for providers that were listed  
7 as in-network in the directory.

8 318. By engaging in the above-listed activities, Magellan did not act fairly or in good faith.

9 319. Magellan's breaches were conscious and deliberate acts, which were designed to and  
10 did unfairly frustrate the agreed common purposes of the contract and which disappointed Plaintiffs'  
11 and the Class's reasonable expectations by denying Plaintiffs and the Class the benefits of the contract.

12 320. Magellan purposefully undertook such acts to deny Plaintiffs the benefits of the  
13 contract, thus enriching Magellan and permitting Magellan to conceal that it was violating applicable  
14 federal and state laws.

15 321. These misrepresentations have directly and proximately caused Plaintiffs and Class  
16 members significant harm, including monetary and non-monetary losses. Among other injuries,  
17 Magellan's misrepresentations have caused millions of dollars in damages; denied Plaintiffs the  
18 benefits to which they were entitled under their health plans and for which they paid premiums (most  
19 notably, coverage for in-network mental health care and access to the supposedly broad network of  
20 available providers); forced Plaintiffs and Class members to delay and/or forgo crucial and necessary  
21 mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually  
22 worthless product; caused Plaintiffs and Class members to incur significant out-of-pocket expenses  
23 for out-of-network provider payments, which greatly exceed the costs Plaintiffs would have incurred  
24 for the same services from in-network providers; caused Plaintiffs and Class members to reduce  
25 spending on necessities and other life costs; induced Plaintiffs and Class members to enroll in Blue  
26 Shield's plan instead of better and/or cheaper plans; prevented Plaintiffs and Class members from  
27 making informed financial and health care decisions; and caused Plaintiffs and Class members to  
28

1 suffer severe emotional and psychological distress due to the unsuccessful provider search and their  
2 inability to receive treatment for themselves and their loved ones.

3 **SEVENTH CAUSE OF ACTION**

4 **Unfair Competition in Violation of California Business & Professions Code § 17200**

5 **(On behalf of all Plaintiffs and Class members)**

6 322. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
7 restate them as if fully set forth herein.

8 323. Section 17200 of the California Business & Professions Code prohibits unfair  
9 competition, including “any unlawful, unfair or fraudulent business act or practice and unfair,  
10 deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with  
11 Section 17500) of Part 3 of Division 7 of the Business and Professions Code.”

12 324. Defendants have engaged in unfair competition by, among other things, engaging in  
13 unlawful, fraudulent, and deceptive advertising and business practices which are unlawful under the  
14 No Surprises Act, the Affordable Care Act, ERISA, the Internal Revenue Code, the MHPAEA,  
15 California Business & Professions Code Section 17500, California Insurance Code Sections 790.02,  
16 10133.15, and 10133.54, Sections 1367.03, 1367.27, and 1360 of the Knox-Keene Act, Section  
17 2240.01 of Chapter 10 of the California Code of Regulations and California Health & Safety Code  
18 Section 1374.72.

19 325. The No Surprises Act, 42 U.S.C. § 300gg-115(a)(2), requires insurers to update and  
20 verify their plans’ provider directories at least every 90 days. Where plans are unable to verify  
21 provider data, they must establish a procedure to remove unverified providers from their directories.

22 326. Defendants violated the No Surprises Act by failing to update the provider directory at  
23 least once every 90 days and by failing to establish a procedure to remove unverified providers from  
24 the directory.

25 327. The Affordable Care Act requires a health insurance company participating in the  
26 Affordable Care Act Marketplace to “publish an up-to-date, accurate, and complete provider directory,  
27 including information on which providers are accepting new patients, the provider's location, contact  
28 information, specialty, medical group, and any institutional affiliations, in a manner that is easily

1 accessible” to enrollees and prospective enrollees. 45 C.F.R. § 156.230(b)(2). Further, the insurance  
2 provider must “identify providers that are not accepting new patients.” 45 C.F.R. § 156.230(b)(1).

3 328. Defendants violated the Affordable Care Act by failing to publish an up-to-date,  
4 accurate, and complete provider directory, and failing to identify providers that are not accepting new  
5 patients.

6 329. Section 720 of ERISA and Section 9820 of the Internal Revenue Code both require  
7 health insurers to verify and update their provider directories not less frequently than once every 90  
8 days, remove a provider from the directory when it is unable to verify the directory information for  
9 that provider, and update the directory within two days of receiving new information from a provider.

10 330. Defendants violated Section 720 of ERISA and Section 9820 of the Internal Revenue  
11 Code by failing to verify and update the provider directory at least once every 90 days, to remove  
12 providers from the directory when Defendants were unable to verify the providers’ information, and  
13 to update the directory within two days of receiving new information from a provider.

14 331. The MHPAEA, incorporated into the Affordable Care Act via 45 C.F.R. § 156.115 and  
15 into ERISA at 29 U.S.C. § 1185a, provides that mental health and substance use disorder benefits must  
16 not be provided on less favorable terms than medical and surgical benefits, specifically with respect  
17 to annual, aggregate, or lifetime limits on coverage, financial requirements, treatment limitations, and  
18 out-of-network coverage.

19 332. Blue Shield, with Magellan’s assistance, violated the MHPAE by providing mental  
20 health and substance use disorder benefits on less favorable terms than medical and surgical benefits.  
21 Among the many ways in which Blue Shield created a disparity in benefits, Blue Shield failed to  
22 maintain an adequate network of mental health providers while maintaining an adequate network of  
23 medical providers within the same geographic area. When Plaintiff and Class members could not find  
24 in-network mental health care as a result of the inadequate network, Blue Shield denied requests to  
25 extend in-network cost-sharing benefits to available out-of-network providers to enable Plaintiff and  
26 Class members to access mental health care. Blue Shield did not apply such treatment limitations to  
27 claims for medical and surgical benefits because in-network providers for medical and surgical  
28 treatments were more widely available under Blue Shield’s health insurance.

1 333. California Business & Professions Code Section 17500 prohibits false advertising by  
2 making it unlawful for a corporation to “make or disseminate or cause to be made or disseminated  
3 before the public” any untrue or misleading statement which the corporation knew or should have  
4 known to be untrue or misleading. It also prohibits such statements when made “as part of a plan or  
5 scheme with the intent not to sell” personal property or services “as so advertised.”

6 334. Defendants violated Business & Professions Code Section 17500 by disseminating  
7 untrue and misleading statements regarding the breadth of their mental health provider network,  
8 providers’ network status and availability, and the mental health benefits included in Blue Shield’s  
9 plans.

10 335. California Insurance Code Section 790.02 prohibits unfair methods of competition and  
11 unfair or deceptive acts or practices in the business of insurance, including making, issuing, or  
12 circulating a statement misrepresenting “the terms of any policy issued or to be issued or the benefits  
13 or advantages promised thereby” or a statement “which is untrue, deceptive, or misleading, and which  
14 is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or  
15 misleading.”

16 336. Defendants violated Insurance Code Section 790.02 by making false statements, which  
17 they knew or should have known to be untrue, deceptive, or misleading, regarding the breadth of their  
18 mental health provider network, the availability of in-network mental health care, and the mental  
19 health coverage provided by Blue Shield’s plans.

20 337. Section 1360 of the Knox-Keene Act prohibits health care services plans from using or  
21 permitting the use of advertising that is untrue or misleading, including any written or printed  
22 statement that is misleading “in any respect which is, or may be significant to an enrollee or subscriber,  
23 or potential enrollee or subscriber.” This Section applies to Evidences of Coverage that cause a  
24 reasonable person “to expect benefits, service charges, or other advantages which the evidence of  
25 coverage does not provide or which the plan issuing such coverage or evidence of coverage does not  
26 regularly make available to enrollees.”

27 338. Defendants violated Section 1360 of the Knox-Keene Act by, among other things,  
28 making misleading statements in their written advertising materials and Evidences of Coverage that

1 would cause a reasonable person to believe that Blue Shield’s plans offer access to a robust and  
2 adequate network of mental health providers, coverage for in-network mental health care, and access  
3 to out-of-network mental health care at in-network cost-sharing rates when in-network care is  
4 unavailable.

5 339. California Insurance Code Section 10133.15 and Section 1367.27 of the Knox-Keene  
6 Act require insurers and health care service plans to “publish and maintain” a provider directory “with  
7 information on contracting providers that deliver health care services” to the plan’s members,  
8 “including those that accept new patients.” This directory “shall not list or include information on a  
9 provider that is not currently under contract with the insurer” or plan. This directory must be made  
10 available online and upon request in hard copy to all members of the public. Insurers must update  
11 their directories “at least quarterly, or more frequently, if required by federal law,” and “at least  
12 weekly ... when informed of” updates from providers. Insurers are required to “take appropriate steps  
13 to ensure the accuracy of the information concerning each provider listed” and must investigate and  
14 rectify reported inaccuracies within 30 business days.

15 340. Defendants violated Insurance Code Section 10133.15 and Section 1367.27 of the  
16 Knox-Keene Act by, among other things, failing to publish and maintain an accurate directory of  
17 mental health providers under Blue Shield’s plans. Defendants’ directory lists an overwhelming  
18 percentage of providers that, contrary to Defendants’ representations, are not actually in-network, long  
19 ago stopped practicing, are not accepting new patients, and do have other inaccurate information.  
20 Defendants do not take reasonable or appropriate steps to ensure the accuracy of the information listed  
21 in their directory. In fact, Defendants intentionally lie about the provider network in order to induce  
22 people to enroll in Blue Shield’s plans based on misinformation.

23 341. California Insurance Code Section 10133.54 and Section 1367.03 of the Knox-Keene  
24 Act require health insurers and health care service plans to provide members with timely access to  
25 care by, among other things, establishing and maintaining a provider network that “has adequate  
26 capacity and availability of licensed health care providers to offer insureds” appointments for mental  
27 health care “within 10 business days of the request for appointment.” When the insurer’s network is  
28 inadequate to meet this standard, the insurer is required to “arrange for the provision of services outside

1 the insurer's contracted network" at a cost to the member not exceeding "applicable in-network  
2 copayments, coinsurance, and deductibles."

3 342. Defendants violated Insurance Code Section 10133.54 and Section 1367.03 of the  
4 Knox-Keene Act by failing to maintain an adequate network of providers to allow Plaintiffs and Class  
5 members to access mental health care within 10 business days of requesting an appointment. Instead,  
6 Plaintiffs were often unable to find any in-network providers with availability and encountered  
7 months-long wait lists for appointments when they did find providers that were actually in-network.  
8 When Plaintiffs alerted Defendants to their difficulties locating timely in-network care, Defendants  
9 did not arrange for Plaintiffs to receive out-of-network care.

10 343. Section 2240.01 of Chapter 10 of the California Code of Regulations requires insurers  
11 to ensure that "there are mental health and substance use disorder professionals with skills appropriate  
12 to care for the mental health and substance use disorder needs of covered persons and with sufficient  
13 capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel  
14 distance of 15 miles of each covered person's residence or workplace. The network must adequately  
15 provide for mental health and substance use disorder treatment, including behavioral health therapy."  
16 Within an insurer's network, "there must be mental health and substance use disorder providers of  
17 sufficient number and type to provide diagnosis and medically necessary treatment through providers  
18 acting within their scope of license and scope of competence." Insurers must also ensure that their  
19 plan members can access information about their mental health benefits, providers, and other relevant  
20 information by contacting the insurer. When medically appropriate care is not available from a  
21 qualified, in-network provider, the insurer must "arrange for the required care with available and  
22 accessible providers outside the network, with the patient responsible for paying only cost-sharing in  
23 an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-  
24 network."

25 344. Defendants violated Section 2240.01 of Chapter 10 of the California Code of  
26 Regulations by, among other things, failing to ensure that they had an adequate network of qualified,  
27 available professionals to meet the needs to their plan members, failing to make accurate information  
28 about plan benefits and providers available to members, and failing to arrange for medically

1 appropriate care from out-of-network providers when members notified them of a lack of available in-  
2 network providers.

3 345. Section 1374.72 of the California Health and Safety Code requires “[e]very health care  
4 service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital,  
5 medical, or surgical coverage shall provide coverage for medically necessary treatment of mental  
6 health and substance use disorders, under the same terms and conditions applied to other medical  
7 conditions.” Cal. Health & Saf. Code § 1374.72(a)(1). The same section further requires: “If services  
8 for the medically necessary treatment of a mental health or substance use disorder are not available in  
9 network within the geographic and timely access standards set by law or regulation, the health care  
10 service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network  
11 services and any medically necessary followup services that, to the maximum extent possible, meet  
12 those geographic and timely access standards.” Cal. Health & Safety Code § 1374.72(d).

13 346. Defendants violated Section 1374.72 of the California Health and Safety Code by  
14 failing to maintain an adequate, accurate network of qualified, available mental health professionals  
15 to meet the needs of plan members, while successfully maintaining a comprehensive and accurate  
16 network of hospital, medical, and surgical providers. Blue Shield further violated Section 1374.72 of  
17 the California Health and Safety Code by outsourcing and inadequately supervising the administration  
18 of its mental health services to Magellan, a third-party entity, while administering their hospital,  
19 medical, and surgical benefits in-house.

20 347. In addition to being unlawful, Defendants’ misrepresentations of the coverage provided  
21 by the plans and the breadth of their provider network constitute unfair and fraudulent business  
22 practices and deceptive advertising. Defendants encourage consumers to enroll in Blue Shield’s plans  
23 using misleading statements about the availability of and coverage for in-network care, and continue  
24 to make misrepresentations to members after they have enrolled in a plan.

25 348. Plaintiffs and other Class members relied on Defendants’ false and deceptive  
26 advertising when deciding to enroll in coverage with Blue Shield.

27 349. As a result of Defendants’ unfair competition, Plaintiffs have suffered injury in fact  
28 and have lost money, including through inflated premiums and improper out-of-network expenses.

1 350. These violations have directly and proximately caused Plaintiffs and Class members  
2 significant harm, including monetary and non-monetary losses. Among other injuries, Defendants’  
3 violations have caused millions of dollars in damages; denied Plaintiffs the benefits to which they  
4 were entitled under their health plans and for which they paid premiums (most notably, coverage for  
5 in-network mental health care and access to the supposedly broad network of available providers);  
6 forced Plaintiffs and Class members to delay and/or forgo crucial and necessary mental health care;  
7 caused Plaintiffs and Class members to pay inflated premiums for a virtually worthless product; caused  
8 Plaintiffs and Class members to incur significant out-of-pocket expenses for out-of-network provider  
9 payments, which greatly exceed the costs Plaintiffs would have incurred for the same services from  
10 in-network providers; caused Plaintiffs and Class members to reduce spending on necessities and other  
11 life costs; induced Plaintiffs and Class members to enroll in Blue Shield’s plan instead of better and/or  
12 cheaper plans; prevented Plaintiffs and Class members from making informed financial and health  
13 care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological  
14 distress due to the unsuccessful provider search and their inability to receive treatment for themselves  
15 and their loved ones.

16 351. Plaintiffs are entitled to injunctive relief and restitution under California Business &  
17 Professions Code § 17200 as a result of these violations.

18 **EIGHTH CAUSE OF ACTION**

19 **Intentional Misrepresentation**

20 **(On behalf of all Plaintiffs and Class members)**

21 352. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
22 restate them as if fully set forth herein.

23 353. Plaintiffs bring this claim as to Defendants’ unlawful conduct on or after November  
24 19, 2022.

25 354. Insurance companies have statutory and common law obligations to provide accurate  
26 and complete information about their health insurance plans.

27 355. Defendants made deceptive affirmative misrepresentations and omissions to Plaintiffs  
28 and Class members by publishing and disseminating misleading informational and marketing

1 materials prior to and during the open enrollment periods. Defendants' misrepresentations were  
2 conveyed in Defendants' online provider directory and other marketing and publicly available  
3 materials. The provider directory itself, on which Plaintiffs, as well as other members and prospective  
4 members, were directed to rely and did rely, intentionally inflated and misled them regarding the  
5 breadth and adequacy of the network and the availability of mental health providers who were taking  
6 new patients.

7 356. The omissions from these same materials include, *inter alia*, any reference to the  
8 limited number of mental health providers who are actually in-network with Defendants, accepted  
9 Defendants' insurance, and were available to see new patients, and to the fact that members and  
10 prospective members are forced to utilize out-of-network providers—and incur substantial costs—  
11 when they need mental health services.

12 357. False representations include, *inter alia*, that Defendants have an adequate network of  
13 providers; that providers listed on the provider directory are in-network and still practicing; that  
14 providers listed as accepting new patients actually accept new patients; that there are sufficient and  
15 available mental health care providers in that network; that members can rely on the directory to find  
16 and contact providers with the listed qualifications offering the listed services; that Defendants  
17 regularly update the directory; and that mental health care coverage is comprehensive.

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

24 359. These misrepresentations and omissions were intended to, and did, induce reliance by  
25 Plaintiffs and Class members as to the services and benefits that would be delivered to them as a result  
26 of choosing Blue Shield's plan. Plaintiffs and Class members chose to enroll in Blue Shield's plan  
27 (instead of better, cheaper options) based on the lies Defendants told about their provider network.  
28 And Plaintiffs and Class members detrimentally relied on Defendants' inaccurate directory when

1 searching for in-network providers. That detrimental reliance caused them to waste countless  
2 frustrating hours searching in vain for available, in-network providers.

3 360. Plaintiffs and Class members reasonably relied on Defendants’ representations and  
4 omissions, as Defendants had unique knowledge of the facts underlying their representations.

5 361. These fraudulent misrepresentations and omissions, when considered as a whole from  
6 the perspective of a reasonable consumer, conveyed that Defendants’ provider directory was, as  
7 federal and state law requires, accurate and broad, and that mental health care would be covered to the  
8 full extent that Defendants had represented. A reasonable consumer would—and Plaintiffs and Class  
9 members did—attach importance to such representations and were induced to enroll in Blue Shield’s  
10 health insurance plan as a result.

11 362. These fraudulent misrepresentations and omissions alleged herein were intentional and  
12 materially misleading. Defendants intentionally led Plaintiffs and Class members to believe that their  
13 network of available providers was adequate and robust in order to induce them to enroll in, and remain  
14 enrolled in, the plans. In reality, however, these misrepresentations and omissions prevented Plaintiffs  
15 and Class members from receiving promised care. Such deception was designed to, and did, allow  
16 Defendants to reap enormous financial gain through increased income (by way of premiums paid by  
17 Plaintiffs and Class members, which were passed on to Magellan) and reduced costs (by way of  
18 delayed, forgone, and unreimbursed care and avoidance of the expenses that would be incurred by  
19 creating and maintaining a robust provider network and an accurate provider directory).

20 363. Defendants willfully and knowingly made the fraudulent misrepresentations and  
21 omissions alleged herein. Alternatively, Defendants made these intentional misrepresentations  
22 recklessly and without regard for their truth. Defendants, as parties to the contracts with in-network  
23 providers and as administrators of the provider network, had access to all the information necessary  
24 to maintain an accurate network directory. Likewise, Defendants continued to make the fraudulent  
25 misrepresentations and omissions even after Plaintiffs, other Class members, and other consumers  
26 notified Defendants of the inaccuracies in the directory and the difficulties members face when trying  
27 to locate in-network mental health care.  
28

1 364. Defendants’ efforts to include affirmative misrepresentations and omissions in their  
2 marketing materials and provider directory were undertaken intentionally to create the appearance of  
3 network adequacy and compliance with federal and state law and to induce individuals to choose Blue  
4 Shield health insurance over competitors’ health insurance and to prevent them from obtaining covered  
5 care, thus increasing their profits. Upon information and belief, Defendants’ competitors offer health  
6 insurance plans that furnish access to more robust mental health provider networks and directories that  
7 more accurately represent their provider networks.

8 365. These misrepresentations have directly and proximately caused Plaintiffs and Class  
9 members significant harm, including monetary and non-monetary losses. Among other injuries,  
10 Defendants’ misrepresentations have caused millions of dollars in damages; denied Plaintiffs the  
11 benefits to which they were entitled under their health plans and for which they paid premiums (most  
12 notably, coverage for in-network mental health care and access to the supposedly broad network of  
13 available providers); forced Plaintiffs and Class members to delay and/or forgo crucial and necessary  
14 mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually  
15 worthless product; caused Plaintiffs and Class members to incur significant out-of-pocket expenses  
16 for out-of-network provider payments, which greatly exceed the costs Plaintiffs would have incurred  
17 for the same services from in-network providers; caused Plaintiffs and Class members to reduce  
18 spending on necessities and other life costs; induced Plaintiffs and Class members to enroll in Blue  
19 Shield’s plan instead of better and/or cheaper plans; prevented Plaintiffs and Class members from  
20 making informed financial and health care decisions; and caused Plaintiffs and Class members to  
21 suffer severe emotional and psychological distress due to the unsuccessful provider search and their  
22 inability to receive treatment for themselves and their loved ones. Plaintiffs’ reliance on Defendants’  
23 misrepresentations was a substantial factor in causing this harm.

24 **NINTH CAUSE OF ACTION**

25 **Negligent Misrepresentation**

26 **(On behalf of all Plaintiffs and Class members)**

27 366. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
28 restate them as if fully set forth herein.

1 367. Plaintiffs plead negligent misrepresentation in the alternative to their claim of  
2 intentional misrepresentation, in the event Defendants' misrepresentations are found to be  
3 unintentional.

4 368. Plaintiffs bring this claim as to Defendants' unlawful conduct on or after November  
5 19, 2022.

6 369. Insurance companies have a statutory and common law duty to provide accurate and  
7 complete information about their health insurance plans.

8 370. Nevertheless, Defendants negligently misrepresented their provider network and the  
9 availability of mental health providers for members because they failed to provide accurate  
10 information with regard to the breadth, qualifications, availability, identities, and contact information  
11 of providers in their network.

12 371. Defendants' false representations include, *inter alia*, that they have an adequate  
13 network of providers; that providers listed on the provider directory are in-network and still practicing;  
14 that there are sufficient and available mental health care providers in that network; that providers listed  
15 as accepting new patients actually accept new patients; that members can rely on the directory to find  
16 and contact providers with the listed qualifications offering the listed services; and that mental health  
17 care coverage is comprehensive.

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

24 373. Defendants had no reasonable grounds for believing the representations were true when  
25 they were made.

26 374. These misrepresentations and omissions were intended to, and did, induce reliance by  
27 Plaintiffs and Class members as to the services and benefits that would be delivered to them as a result  
28 of choosing Blue Shield's plan. Plaintiffs and Class members chose to enroll in Blue Shield's plans

1 (instead of better, cheaper options) based on the lies Defendants told about their provider network.  
2 And Plaintiffs and Class members detrimentally relied on Defendants' inaccurate directory when  
3 searching for in-network providers.

4 375. Plaintiffs and the Class reasonably relied upon the information that Defendants  
5 provided.

6 376. Defendants have not used reasonable care or competence in providing accurate  
7 information about their network of providers and in publishing the provider directory.

8 377. These misrepresentations have directly and proximately caused Plaintiffs and Class  
9 members significant harm, including monetary and non-monetary losses. Among other injuries,  
10 Defendants' misrepresentations have caused millions of dollars in damages; denied Plaintiffs the  
11 benefits to which they were entitled under their health plans and for which they paid premiums (most  
12 notably, coverage for in-network mental health care and access to the supposedly broad network of  
13 available providers); forced Plaintiffs and Class members to delay and/or forgo crucial and necessary  
14 mental health care; caused Plaintiffs and Class members to pay inflated premiums for a virtually  
15 worthless product; caused Plaintiffs and Class members to incur significant out-of-pocket expenses  
16 for out-of-network provider payments, which greatly exceed the costs Plaintiffs would have incurred  
17 for the same services from in-network providers; caused Plaintiffs and Class members to reduce  
18 spending on necessities and other life costs; induced Plaintiffs and Class members to enroll in Blue  
19 Shield's plan instead of better and/or cheaper plans; prevented Plaintiffs and Class members from  
20 making informed financial and health care decisions; and caused Plaintiffs and Class members to  
21 suffer severe emotional and psychological distress due to the unsuccessful provider search and their  
22 inability to receive treatment for themselves and their loved ones.

23 378. Plaintiffs' reliance on Defendants' misrepresentations was a substantial factor in  
24 causing this harm.

25 **TENTH CAUSE OF ACTION**

26 **Restitution for Unjust Enrichment**

27 **(On behalf of all Plaintiffs and Class members)**

28

1 379. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
2 restate them as if fully set forth herein, except those allegations regarding the existence of enforceable  
3 contracts requiring Defendants to provide Plaintiffs with an accurate provider directory and adequate  
4 mental health provider network. Plaintiffs assert this cause of action for restitution in the alternative  
5 to their breach of contract claims.

6 380. Plaintiffs bring this claim as to Defendants' unlawful conduct on or after November  
7 19, 2022.

8 381. Defendants have been and continue to be significantly and unjustly enriched as a result  
9 of their inaccurate provider directory and inadequate mental health provider network. Because  
10 Defendants portrayed their mental health provider network as robust and mental health coverage as  
11 comprehensive, Plaintiffs and countless other individuals selected Blue Shield's plans over other  
12 (better and/or cheaper) plans, paid premiums commensurate with the purportedly robust provider  
13 network, and did not receive the coverage or care to which they were entitled. As a result, Defendants'  
14 market share and profits increased and their costs decreased, thus unjustly enriching them at Plaintiffs'  
15 and Class members' expense. Defendants' lies artificially inflated the price of, and induced Plaintiffs  
16 to enroll in, Blue Shield's plan, which increased the premiums paid to Defendants.

17 382. Plaintiffs and Class members have conferred a benefit on Defendants by enrolling in  
18 Blue Shield health insurance plans and thereby directing their medical premiums to Blue Shield, who  
19 then passes on a portion of its profits to Magellan as the designated MHSA.

20 383. Plaintiffs and Class members have further conferred a benefit on Defendants because  
21 Defendants' inaccurate directory and inadequate network forces Plaintiffs and Class members to pay  
22 a portion of the mental health care expenses that Defendants represented would be covered.  
23 Effectively, Defendants represent that their insurance broadly covers mental health care, including  
24 care from providers listed in their directory, yet their bait-and-switch tactics ensure that they do not  
25 pay the full costs of actually covering mental health care services.

26 384. Defendants have thus enriched themselves by reaping the benefits of increased  
27 membership, while reducing or eliminating their own coverage, reimbursement, and other financial  
28

1 duties. This and other benefits were obtained at the expense of Plaintiffs and Class members, who did  
2 not receive the full value of what Defendants promised.

3 385. In addition, Defendants' inflated mental health provider network makes it appear that  
4 they comply with federal and state statutory and regulatory requirements that their provider network  
5 be sufficient, adequate, and accurately reflected in the directory, thereby saving them the costs of  
6 actual compliance with these requirements and shielding them from government investigation, and the  
7 associated costs, at the expense of their members.

8 386. A restitution cause of action based on a theory of unjust enrichment is appropriate  
9 because Defendants failed to make restitution to Plaintiffs and Class members for their economic and  
10 non-economic harms, including out-of-pocket costs unjustly incurred, and more.

11 387. It is inequitable and unjust for Defendants to retain the benefits from falsely portraying  
12 their provider network in a way that increases enrollment while decreasing Defendants' obligations to  
13 do exactly what they say they will with respect to providing coverage for mental health treatment.

14 388. These expenses and inconveniences should have been borne by Defendants. The  
15 profits made by Defendants as a result of their misconduct should be disgorged.

16 389. Defendants must restore to Plaintiffs and Class members those premiums received from  
17 them and their employers. Plaintiffs are entitled to restitution of these funds because Defendants knew  
18 and had reason to know that they falsely portrayed their non-existent provider network and the non-  
19 existent coverage available under the plans, inducing Plaintiffs to enroll in the plans, which then  
20 caused a portion of Plaintiffs' payments to be passed on to Magellan.

21 **ELEVENTH CAUSE OF ACTION**

22 **Improper Denial of Benefits under ERISA**

23 **(On behalf of Jennifer Roiz and Class members who purchased or enrolled in an ERISA plan)**

24 390. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
25 restate them as if fully set forth herein.

26 391. Plaintiff Jennifer Roiz purchased and/or enrolled in an ERISA plan. She brings this  
27 count on her own behalf and on behalf of those similarly situated pursuant to 29 U.S.C. § 1132(a)(1)(B)  
28 for damages at law.

1 392. Blue Shield and Magellan were jointly responsible for reviewing, processing, and  
2 making final decisions approving or denying Plaintiff’s and Class members’ requests and claims under  
3 the plan.

4 393. Defendants improperly denied Plaintiff’s and Class members’ requests for coverage  
5 and reimbursement for health services covered under the terms of the plan and Defendants’ agreements  
6 under the plan.

7 394. Defendants improperly denied requests for coverage and reimbursement, in part, based  
8 on the faulty premise that in-network providers were available to provide the requested services.

9 395. In reality, because of Defendants’ ghost network, in-network providers within a  
10 reasonable distance of Plaintiff were unavailable to provide Plaintiff’s requested services. This lack  
11 of providers—despite the false representations in Defendants’ directory that numerous in-network  
12 providers were available to provide the requested services—denied Plaintiff the coverage and benefits  
13 due to her under the plan.

14 396. Defendants improperly failed to provide the health coverage affirmed under the plan;  
15 failed to reimburse Plaintiff in accordance with the terms of the plan; and failed to accurately apply  
16 Plaintiff’s expenditures to deductibles in accordance with the terms of the plan.

17 **TWELFTH CAUSE OF ACTION**

18 **Breach of Fiduciary Duty under ERISA**

19 **(On behalf of Jenniffer Roiz and Class members who purchased or enrolled in an ERISA plan)**

20 397. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
21 restate them as if fully set forth herein.

22 398. Ms. Roiz purchased and/or enrolled in an ERISA plan. She brings this count on her  
23 own behalf and on behalf of those similarly situated pursuant to 29 U.S.C. §§ 1109(a), 1132(a)(2) &  
24 (a)(3) for equitable relief and damages at law.

25 399. Defendants are responsible for interpreting the plans they administer and formulating  
26 policies and guidance for beneficiaries under the plans. Defendants are also responsible for  
27 maintaining the accuracy of plan documents, including the provider directory. Defendants are  
28 additionally responsible for making final and binding decisions about whether to approve coverage

1 requested by plan members. As such, Defendants exercise discretionary authority with respect to the  
2 administration of the plans and the payment of plan benefits. Defendants are therefore ERISA  
3 fiduciaries as defined by 29 U.S.C. §§ 1002(21)(A) and 1104(a).

4 400. As ERISA fiduciaries, and pursuant to 29 U.S.C. § 1104(a), Defendants have a duty of  
5 loyalty to plan participants and beneficiaries which requires them to discharge their duties “solely in  
6 the interests of the participants and beneficiaries” of the plans they administer and for the “exclusive  
7 purpose” of providing benefits to participants and beneficiaries and paying reasonable expenses of  
8 administering the plans.

9 401. Defendants also owe plan participants and beneficiaries a duty of care, which requires  
10 them to act with reasonable “care, skill, prudence, and diligence” and in accordance with the terms of  
11 the plan.

12 402. Defendants violated their fiduciary duties of loyalty and care to Plaintiff and Class  
13 members by grossly inflating the size of their provider network and exaggerating plan benefits in order  
14 to increase enrollment and profits. Defendants knew that beneficiaries would not receive the coverage  
15 and benefits falsely represented in plan documents, including the provider directory, but made these  
16 misrepresentations to enrich themselves at the expense of Plaintiff and Class members.

17 403. Defendants’ misrepresentations, omissions, and false statements about the size of their  
18 provider network harmed the ERISA plan as a whole by measurably reducing the value of the plan’s  
19 assets (here, its provider network).

20 404. Recovery of denied benefits under 29 U.S.C. § 1132(a)(1)(B) is insufficient to remedy  
21 Ms. Roiz and Class members’ injury. Ms. Roiz experienced pain and suffering, spent hours fruitlessly  
22 searching for in-network care while suffering from postpartum depression, and has navigated life  
23 without mental health treatment due to her inability to access in-network mental health care because  
24 of Defendants’ inaccurate and inadequate provider directory and network.

25 405. Plaintiff seeks mandatory injunctive relief in the form of an order requiring Defendants  
26 to revise and regularly update their provider directory to ensure it is accurate and current. Defendants  
27 should be enjoined from further publishing a directory that includes erroneous information about  
28

1 providers who do not exist, are no longer practicing, are not accepting new patients, are not providing  
2 the specified services or specialties, or are not part of the Defendants’ network.

3 406. Plaintiff further seeks a mandatory injunction requiring the Defendants to establish and  
4 maintain an adequate network of mental health providers.

5 407. Plaintiff further requests surcharge to prevent unjust enrichment of the Defendants.  
6 The Defendants pocketed inflated premiums from Class members for years based on their inaccurate  
7 provider directory and misleading marketing materials.

8 408. Plaintiff further requests equitable relief to make her whole for her inability to obtain  
9 care and treatment under the plan.

11 **THIRTEENTH CAUSE OF ACTION**

12 **Parity in Mental Health Benefits under ERISA & MHPAEA – Blue Shield**

13 **(On behalf of Jenniffer Roiz and Class members who purchased or enrolled in an ERISA plan)**

14 409. Plaintiffs incorporate by reference all allegations in this Amended Complaint and  
15 restate them as if fully set forth herein.

16 410. Ms. Roiz purchased and/or enrolled in an ERISA plan. She brings this count on her  
17 own behalf and on behalf of those similarly situated pursuant to 29 U.S.C. §§ 1132(a)(1)(B), (a)(3),  
18 and 1185a for equitable relief and damages at law.

19 411. Blue Shield, in administering a group health plan that provides both medical and  
20 surgical benefits and mental health benefits, included financial requirements and treatment limitations  
21 applicable to mental health benefits that were more restrictive than those applied to substantially all  
22 medical and surgical benefits covered by the plan.

23 412. 29 C.F.R. § 2590.712(c)(4)(ii)(D) provides that nonquantitative treatment limitations  
24 include “[s]tandards related to network composition, including but not limited to ... procedures for  
25 ensuring the network includes an adequate number of each category of provider and facility to provide  
26 services under the plan or coverage.” 29 C.F.R. § 2590.712(c)(4)(iii)(A) requires insurers to “collect  
27 and evaluate relevant data ... on relevant outcomes related to access to mental health and substance  
28

1 use disorder benefits and medical/surgical benefits.” Finally, 29 C.F.R. § 2590.712(c)(4)(iii)(B)  
2 requires that where there are “material differences in access to mental health and substance abuse  
3 disorders as compared to medical/surgical benefits” the insurer must take “reasonable action ... to  
4 address the material differences to ensure compliance.”

5  
6 413. Among the many ways in which Blue Shield created a disparity in benefits, Blue Shield  
7 failed to maintain an adequate network of mental health providers while maintaining an adequate  
8 network of medical providers within the same geographic area. When Plaintiff and Class members  
9 could not find in-network mental health care as a result of the inadequate network, Blue Shield denied  
10 requests to extend in-network cost-sharing benefits to available out-of-network providers to enable  
11 Plaintiff and Class members to access mental health care. Blue Shield did not apply such treatment  
12 limitations to claims for medical and surgical benefits because in-network providers for medical and  
13 surgical treatments were more widely available under Blue Shield’s health insurance.

14 414. Blue Shield did not collect and evaluate relevant data on access to mental health  
15 benefits and medical/surgical benefits, carefully consider the impact on parity, or take reasonable  
16 action to address the material differences in network adequacy.

17 415. Blue Shield’s processes for ensuring network adequacy for mental health providers  
18 were less rigorous and less effective than the processes applied to medical/surgical providers.

19 416. By falsely representing the availability of in-network mental health providers and by  
20 not honoring their legal obligations to cover out-of-network providers at in-network cost-sharing rates  
21 when in-network care is not available, Blue Shield required Plaintiffs and Class members to  
22 disproportionately seek treatment from out-of-network providers and pay higher costs than those  
23 required of beneficiaries seeking medical and surgical benefits. This financial requirement was more  
24 restrictive for mental health benefits than for medical or surgical benefits.

25 **DEMAND FOR RELIEF**

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

- 27 a. declaring that the instant action may be maintained as a class action under Rule 23 of  
28 the Federal Rules of Civil Procedure, certifying the Class and Sub-Classes as requested herein,

- 1 designating Plaintiffs as the Class Representatives, and appointing the undersigned counsel as  
2 Class Counsel;
- 3 b. awarding all injunctive relief permitted by law or equity;
- 4 c. awarding compensatory damages, restitution, disgorgement, and any other relief  
5 permitted by law or equity;
- 6 d. awarding statutory damages and penalties in addition to actual damages;
- 7 e. awarding treble damages;
- 8 f. awarding punitive damages in an amount deemed appropriate by the Court;
- 9 g. awarding Plaintiffs and the Class pre-judgment and post-judgment interest;
- 10 h. awarding Plaintiffs reasonable attorneys' fees and costs; and
- 11 i. awarding Plaintiffs and the Class such other relief as this Court may deem just and  
12 proper under the circumstances.

13 \* \* \*

14 **DEMAND FOR JURY TRIAL**

15 Plaintiffs hereby demand a trial by jury.

16  
17 Dated: March 24, 2026

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**ATTESTATION OF FILER**

I, Jacob Gardener, am the ECF user whose ID and password are being used to file this document. In compliance with Civil L.R. 5-1(i)(3), I hereby attest that all counsel have concurred in this filing.

Dated: March 24, 2026

*/s/ Jacob Gardener*  
Jacob Gardener

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