26-813-cv

United States Court of Appeals

for the

Second Circuit

JANE DOE, on behalf of BABY DOE, a minor, PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated,

Plaintiffs-Appellants,

– v. –

ANTHEM HEALTHCHOICE ASSURANCE, INC, DBA Anthem Blue Cross and Blue Shield, DBA Anthem Blue Cross,

Defendant-Appellee,

ANTHEM HP, LLC, DBA Anthem Blue Cross and Blue Shield HP, DBA Anthem Blue Cross HP,

Defendant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JOINT APPENDIX

TROUTMAN PEPPER LOCKE
Attorneys for Defendant-Appellee
875 Third Avenue
New York, New York 10022
(212) 704-6000

WALDEN HARAN WILLIAMS LLP
Attorneys for Plaintiffs-Appellants
250 Vesey Street, 27th Floor
New York, New York 10281
(212) 335-2030

(For Continuation of Appearance See Inside Cover)

COUNSEL PRESS
A Proceed Service
The Appellate Experts®
(800) 4-APPEAL • (394390)

POLLOCK COHEN LLP
Attorneys for Plaintiffs-Appellants
111 Broadway, Suite 1804
New York, New York 10006
(646) 517-0542

TABLE OF CONTENTS

JA-1

CLOSED,APPEAL,ECF

U.S. District Court
Southern District of New York (Foley Square)
CIVIL DOCKET FOR CASE #: 1:24-cv-08012-JPC

Doe et al v. Anthem Healthchoice Assurance, Inc. et al
Assigned to: Judge John P. Cronan
Demand: $100,000
Cause: 05:8902 Contracting Authority of OPM - Group Health Insurance

Date Filed: 10/22/2024
Date Terminated: 03/05/2026
Jury Demand: Plaintiff
Nature of Suit: 110 Insurance
Jurisdiction: Federal Question

Plaintiff

Jane Doe
on behalf of Baby Doe, a minor

represented by **Jacob Samuel Gardener**
Walden Macht Haran & Williams LLP
250 Vesey St
Ste 27th Floor
New York, NY 10281
212-335-2030
Email: jgardener@whwllp.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Anna Menkova
111 Broadway
Suite 1804
New York, NY 10006
917-626-0155
Email: anna@pollockcohen.com
ATTORNEY TO BE NOTICED

Samuel Rosh
Walden Macht Haran & Williams LLP
250 Vesey Street
27th Floor
10281
New York, NY 10281
212-335-2030
Email: srosh@whwllp.com
ATTORNEY TO BE NOTICED

Steve Cohen
Pollock Cohen LLP
Mr.
111 Broadway
Suite 1804
New York
New York, NY 10006
917-364-4197

Email: scohen@pollockcohen.com
ATTORNEY TO BE NOTICED

Plaintiff

Patricia Cavallaro-Kearins
on behalf of themselves and all others similarly situated

represented by **Jacob Samuel Gardener**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Adam Lewis Pollock
Pollock Cohen LLP
111 Broadway, Suite 1804
New York, NY 10006
212-337-5361
Email: Adam@PollockCohen.com
ATTORNEY TO BE NOTICED

Anna Menkova
(See above for address)
ATTORNEY TO BE NOTICED

Samuel Rosh
(See above for address)
ATTORNEY TO BE NOTICED

Steve Cohen
(See above for address)
ATTORNEY TO BE NOTICED

V.

Defendant

Anthem Healthchoice Assurance, Inc.
doing business as
Anthem Blue Cross and Blue Shield
doing business as
Anthem Blue Cross

represented by **Matthew Joel Aaronson**
Troutman Pepper Locke LLP
875 Third Avenue
New York, NY 10022
212-704-6006
Fax: 212-704-5901
Email: matthew.aaronson@troutman.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Adam P. Feinberg
Miller & Chevalier Chartered
900 16th Street N.W.
Washington, DC 20006
202-626-6087
Fax: 202-626-5801
Email: afeinberg@milchev.com
ATTORNEY TO BE NOTICED

Defendant

JA-3

Anthem HP, LLC
TERMINATED: 01/23/2025
doing business as
Anthem Blue Cross and Blue Shield HP
TERMINATED: 01/23/2025
doing business as
Anthem Blue Cross HP
TERMINATED: 01/23/2025

represented by **Matthew Joel Aaronson**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
10/22/2024	1	COMPLAINT against Anthem HP, LLC, Anthem Healthchoice Assurance, Inc.. (Filing Fee $ 405.00, Receipt Number ANYSDC-30073995)Document filed by JANE (A PSEUDONYM) DOE, Patricia Cavallaro-Kearins..(Cohen, Steve) (Entered: 10/22/2024)
10/23/2024		*****NOTICE TO ATTORNEY TO ELECTRONICALLY FILE CIVIL COVER SHEET. Notice to Attorney Steve Cohen. Attorney must electronically file the Civil Cover Sheet. Use the event type Civil Cover Sheet found under the event list Other Documents. (jgo)** (Entered: 10/23/2024)
10/23/2024		*****NOTICE TO ATTORNEY REGARDING PARTY MODIFICATION. Notice to attorney Steve Cohen. The party information for the following party/parties has been modified: JANE DOE; Patricia Cavallaro-Kearins; Anthem Healthchoice Assurance, Inc.; Anthem HP, LLC. The information for the party/parties has been modified for the following reason/reasons: party name was entered in all caps; party text was omitted; alias party name was omitted;. (jgo)** (Entered: 10/23/2024)
10/23/2024		CASE OPENING INITIAL ASSIGNMENT NOTICE: The above-entitled action is assigned to Judge John P. Cronan. Please download and review the Individual Practices of the assigned District Judge, located at https://nysd.uscourts.gov/judges/district-judges. Attorneys are responsible for providing courtesy copies to judges where their Individual Practices require such. Please download and review the ECF Rules and Instructions, located at https://nysd.uscourts.gov/rules/ecf-related-instructions..(jgo) (Entered: 10/23/2024)
10/23/2024		Magistrate Judge Jennifer Willis is designated to handle matters that may be referred in this case. Pursuant to 28 U.S.C. Section 636(c) and Fed. R. Civ. P. 73(b)(1) parties are notified that they may consent to proceed before a United States Magistrate Judge. Parties who wish to consent may access the necessary form at the following link: https://nysd.uscourts.gov/sites/default/files/2018-06/AO-3.pdf. (jgo) (Entered: 10/23/2024)
10/23/2024		Case Designated ECF. (jgo) (Entered: 10/23/2024)
10/23/2024	2	CIVIL COVER SHEET filed..(Cohen, Steve) (Entered: 10/23/2024)
10/23/2024	3	FIRST RULE 7.1 CORPORATE DISCLOSURE STATEMENT. No Corporate Parent. Document filed by Jane Doe, Patricia Cavallaro-Kearins..(Cohen, Steve) (Entered: 10/23/2024)
11/04/2024	4	NOTICE OF APPEARANCE by Jacob Samuel Gardener on behalf of Jane Doe, Patricia Cavallaro-Kearins..(Gardener, Jacob) (Entered: 11/04/2024)
11/04/2024	5	NOTICE OF APPEARANCE by Samuel Rosh on behalf of Jane Doe, Patricia Cavallaro-Kearins..(Rosh, Samuel) (Entered: 11/04/2024)
11/04/2024	6	REQUEST FOR ISSUANCE OF SUMMONS as to ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a

		ANTHEM BLUE CROSS, re: 1 Complaint. Document filed by Jane Doe, Patricia Cavallaro-Kearins..(Gardener, Jacob) (Entered: 11/04/2024)
11/04/2024	7	REQUEST FOR ISSUANCE OF SUMMONS as to ANTHEM HP, LLC, d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD HP, and d/b/a ANTHEM BLUE CROSS HP, re: 1 Complaint. Document filed by Jane Doe, Patricia Cavallaro-Kearins..(Gardener, Jacob) (Entered: 11/04/2024)
11/06/2024	8	ELECTRONIC SUMMONS ISSUED as to Anthem Healthchoice Assurance, Inc...(jgo) (Entered: 11/06/2024)
11/06/2024	9	ELECTRONIC SUMMONS ISSUED as to Anthem HP, LLC..(jgo) (Entered: 11/06/2024)
11/06/2024	10	WAIVER OF SERVICE RETURNED EXECUTED. Anthem HP, LLC waiver sent on 11/5/2024, answer due 1/6/2025; Anthem Healthchoice Assurance, Inc. waiver sent on 11/5/2024, answer due 1/6/2025. Document filed by Jane Doe; Patricia Cavallaro-Kearins.. (Gardener, Jacob) (Entered: 11/06/2024)
11/14/2024	11	NOTICE OF APPEARANCE by Adam Lewis Pollock on behalf of Patricia Cavallaro-Kearins..(Pollock, Adam) (Entered: 11/14/2024)
12/12/2024	12	CONSENT LETTER MOTION for Extension of Time to File Answer re: 1 Complaint addressed to Judge John P. Cronan from Matthew J. Aaronson dated 12/12/2024. Document filed by Anthem Healthchoice Assurance, Inc., Anthem HP, LLC..(Aaronson, Matthew) (Entered: 12/12/2024)
12/13/2024	13	ORDER granting 12 Letter Motion for Extension of Time to Answer The request is granted. Defendants' deadline to respond to the Complaint is extended to February 14, 2025. The Clerk of Court is respectfully directed to close Docket Number 12. SO ORDERED. Anthem HP, LLC answer due 2/14/2025; Anthem Healthchoice Assurance, Inc. answer due 2/14/2025. (Signed by Judge John P. Cronan on 12/13/2024) (jca) (Entered: 12/13/2024)
01/21/2025	14	NOTICE OF VOLUNTARY DISMISSAL pursuant to Rule 41(a)(1)(A)(i) of the Federal Rules of Civil Procedure, the plaintiff(s) and or their counsel(s), hereby give notice that the above-captioned action is voluntarily dismissed, without prejudice and without costs against the defendant(s) Anthem HP, LLC. Document filed by Jane Doe, Patricia Cavallaro-Kearins. **Proposed document to be reviewed and processed by Clerk's Office staff (No action required by chambers).**..(Cohen, Steve) (Entered: 01/21/2025)
01/22/2025		*****NOTICE TO COURT REGARDING NOTICE OF VOLUNTARY DISMISSAL Document No. 14 Notice of Voluntary Dismissal was reviewed and referred to Judge John P. Cronan for approval for the following reason(s): the plaintiff(s) filed their voluntary dismissal and it did not dismiss all of the parties or the action in its entirety. (km)** (Entered: 01/22/2025)
01/23/2025	15	NOTICE OF VOLUNTARY DISMISSAL WITHOUT PREJUDICE PLEASE TAKE NOTICE THAT, pursuant to Federal Rule of Civil Procedure 41(a)(1)(A)(i), Plaintiffs Patricia Cavallaro-Kearins and Jane Doe on behalf of her child Baby Doe, a minor, hereby voluntarily dismiss Anthem HP, LLC from this action without prejudice. For the avoidance of doubt, Plaintiffs do not dismiss their claims against defendant Anthem Healthchoice Assurance, Inc. The Clerk of Court is directed to terminate Defendant Anthem HP, LLC's participation in this matter. Defendant Anthem Healthchoice Assurance, Inc.'s participation remains unchanged. SO ORDERED. (Signed by Judge John P. Cronan on 1/23/2025) (jca) (Entered: 01/23/2025)
02/13/2025	16	**FILING ERROR - PDF ERROR -** MOTION for Adam Peter Feinberg to Appear Pro Hac Vice . Filing fee $ 200.00, receipt number ANYSDC-30617920. **Motion and**

		supporting papers to be reviewed by Clerk's Office staff. Document filed by Anthem Healthchoice Assurance, Inc.. (Attachments: # 1 Affidavit In Support of Motion for Admission Pro Hac Vice, # 2 Proposed Order Granting Motion for Admission Pro Hac Vice, # 3 Exhibit VA Certificate of Good Standing, # 4 Exhibit DC Certificate of Good Standing, # 5 Exhibit Supplemental List of Admissions).(Feinberg, Adam) Modified on 2/14/2025 (bc). (Entered: 02/13/2025)
02/14/2025		**>>>NOTICE REGARDING DEFICIENT MOTION TO APPEAR PRO HAC VICE. Notice to RE-FILE Document No. 16 MOTION for Adam Peter Feinberg to Appear Pro Hac Vice . Filing fee $ 200.00, receipt number ANYSDC-30617920. Motion and supporting papers to be reviewed by Clerk's Office staff... The filing is deficient for the following reason(s): missing Certificate of Good Standing from Supreme Court of Virginia;. Re-file the motion as a Motion to Appear Pro Hac Vice - attach the correct signed PDF - select the correct named filer/filers - attach valid Certificates of Good Standing issued within the past 30 days - attach Proposed Order.. (bc)** (Entered: 02/14/2025)
02/14/2025	17	LETTER MOTION for Conference *(Pre-Motion Conference)* addressed to Judge John P. Cronan from Matthew J. Aaronson dated 2/14/2025. Document filed by Anthem Healthchoice Assurance, Inc...(Aaronson, Matthew) (Entered: 02/14/2025)
02/20/2025	18	LETTER RESPONSE in Opposition to Motion addressed to Judge John P. Cronan from Jacob Gardener dated 02/20/2025 re: 17 LETTER MOTION for Conference *(Pre-Motion Conference)* addressed to Judge John P. Cronan from Matthew J. Aaronson dated 2/14/2025. . Document filed by Jane Doe, Patricia Cavallaro-Kearins..(Gardener, Jacob) (Entered: 02/20/2025)
02/21/2025	19	ORDER denying 17 Letter Motion for Conference The Court is in receipt of Defendant's pre-motion letter in anticipation of its forthcoming motion to dismiss and Plaintiffs' letter in response. Dkts. 17-18. The Court concludes that a pre-motion conference is unnecessary and sets the following briefing schedule for Defendant's motion to dismiss. Defendant's motion is due by March 28, 2025. Plaintiffs' opposition is due by May 2, 2025. Defendant's reply is due by May 30, 2025. The Clerk of Court is respectfully directed to close Docket Number 17. SO ORDERED.. (Signed by Judge John P. Cronan on 2/21/2025) (jca) (Entered: 02/21/2025)
02/21/2025		Set/Reset Deadlines: Motions due by 3/28/2025. Responses due by 5/2/2025 Replies due by 5/30/2025. (jca) (Entered: 02/21/2025)
02/26/2025	20	MOTION for Adam Peter Feinberg to Appear Pro Hac Vice . **Motion and supporting papers to be reviewed by Clerk's Office staff.** Document filed by Anthem Healthchoice Assurance, Inc.. (Attachments: # 1 Affidavit of Adam P. Feinberg, # 2 Proposed Order Granting Motion for Admission Pro Hac Vice, # 3 Exhibit VA Certificate of Good Standing, # 4 Exhibit DC Certificate of Good Standing, # 5 Exhibit Supplemental List of Admissions).(Feinberg, Adam) (Entered: 02/26/2025)
02/27/2025		**>>>NOTICE REGARDING PRO HAC VICE MOTION. Regarding Document No. 20 MOTION for Adam Peter Feinberg to Appear Pro Hac Vice . Motion and supporting papers to be reviewed by Clerk's Office staff.. The document has been reviewed and there are no deficiencies. (rju)** (Entered: 02/27/2025)
02/28/2025	21	ORDER FOR ADMISSION PRO HAC VICE granting 20 Motion to Appear Pro Hac Vice The motion of Adam P. Feinberg for admission to practice Pro Hac Vice in the above captioned action is granted. The Clerk of Court is respectfully directed to close Docket Number 20. SO ORDERED. (Signed by Judge John P. Cronan on 2/28/2025) (jca) (Entered: 02/28/2025)

03/28/2025	22	ORDER: The Court notes that neither party has moved for a stay of discovery pending the Court's disposition of Defendant's motion to dismiss. Therefore, the parties shall file a proposed civil Case Management Plan and Scheduling Order by April 4, 2025. A model order can be found at https://www.nysd.uscourts.gov/hon-john-p-cronan. (Signed by Judge John P. Cronan on 3/28/2025) (rro) (Entered: 03/28/2025)
03/28/2025	23	NOTICE OF APPEARANCE by Anna Menkova on behalf of Patricia Cavallaro-Kearins, Jane Doe..(Menkova, Anna) (Entered: 03/28/2025)
03/28/2025	24	MOTION to Dismiss . Document filed by Anthem Healthchoice Assurance, Inc... (Aaronson, Matthew) (Entered: 03/28/2025)
03/28/2025	25	MEMORANDUM OF LAW in Support re: 24 MOTION to Dismiss . . Document filed by Anthem Healthchoice Assurance, Inc...(Aaronson, Matthew) (Entered: 03/28/2025)
03/28/2025	26	DECLARATION of Brendan G. Stuhan in Support re: 24 MOTION to Dismiss .. Document filed by Anthem Healthchoice Assurance, Inc.. (Attachments: # 1 Exhibit A - 2013 OPM-BCBSA Contract, # 2 Exhibit B - 2022 OPM-BCBSA Contract, # 3 Exhibit C - 2018 Amendment to 2013 Contract, # 4 Exhibit D - 2019 Amendment to 2013 Contract, # 5 Exhibit E - 2020 Amendment to 2013 Contract, # 6 Exhibit F - 2021 Amendment to 2013 Contract, # 7 Exhibit G - 2023 Amendment to 2022 Contract, # 8 Exhibit H - 2024 Amendment to 2022 Contract, # 9 Exhibit I - 2018 Statement of Benefits, # 10 Exhibit J - 2019 Statement of Benefits, # 11 Exhibit K - 2020 Statement of Benefits, # 12 Exhibit L - 2021 Statement of Benefits, # 13 Exhibit M - 2022 Statement of Benefits, # 14 Exhibit N - 2023 Statement of Benefits, # 15 Exhibit O - 2024 Statement of Benefits).(Aaronson, Matthew) (Entered: 03/28/2025)
04/02/2025	27	CONSENT LETTER MOTION to Stay *Discovery Pending Decision on Anthem's Motion to Dismiss* addressed to Judge John P. Cronan from Matthew J. Aaronson dated 4/2/2025. Document filed by Anthem Healthchoice Assurance, Inc...(Aaronson, Matthew) (Entered: 04/02/2025)
04/03/2025	28	ORDER granting 27 Letter Motion to Stay "A motion to dismiss does not automatically stay discovery, and discovery should not be routinely stayed simply on the basis that a motion to dismiss has been filed." Khan v. New York City, No. 24 Civ. 2168 (JAM), 2024 WL 4814236, at *4 (E.D.N.Y. Nov. 18, 2024) (internal quotation marks omitted). Rather, "upon a showing of good cause a district court has considerable discretion to stay discovery pursuant to Fed. R. Civ. P. 26(c)." Hong Leong Fin. Ltd. (Singapore) v. Pinnacle Performance Ltd., 297 F.R.D. 69, 72 (S.D.N.Y. 2013) (internal quotation marks omitted). "A court determining whether to grant a stay of discovery pending a motion must look to the particular circumstances and posture of each case," and in evaluating whether to stay discovery pending the disposition of a motion to dismiss, "courts typically consider: (1) whether the [d]efendants ha[ve] made a strong showing that the plaintiff's claim is unmeritorious; (2) the breadth of discovery and the burden of responding to it; and (3) the risk of unfair prejudice to the party opposing the stay. Sharma v. Open Door NY Home Care Servs., Inc., 345 F.R.D. 565, 568 (E.D.N.Y. 2024) (internal quotation marks omitted). After weighing these factors, the Court concludes that good cause exists to stay discovery in this case. Without purporting to pass on the merits of the pending motion to dismiss, Defendant has challenged liability on, inter alia, preemption and exhaustion grounds. See Dkt. 25. Disposition of the issue of whether Plaintiff has successfully stated a claim in the first instance would avoid any prejudice from subjecting Defendant to broad discovery in the interim. As Plaintiff has joined the motion to stay discovery, the Court sees no resulting prejudice to Plaintiff. Accordingly, discovery in this matter is stayed pursuant to Federal Rule of Civil Procedure 26(c) pending the Court's ruling on Defendant's motion to dismiss. The parties' April 4, 2025 deadline to submit a case management plan is adjourned sine die.

		The Clerk of Court is respectfully directed to close Docket Number 27. SO ORDERED. (Signed by Judge John P. Cronan on 4/3/2025) (jca) (Entered: 04/03/2025)
05/02/2025	29	MEMORANDUM OF LAW in Opposition re: 24 MOTION to Dismiss . . Document filed by Patricia Cavallaro-Kearins, Jane Doe..(Gardener, Jacob) (Entered: 05/02/2025)
05/30/2025	30	REPLY MEMORANDUM OF LAW in Support re: 24 MOTION to Dismiss . . Document filed by Anthem Healthchoice Assurance, Inc...(Aaronson, Matthew) (Entered: 05/30/2025)
03/02/2026	31	OPINION AND ORDER re: 24 MOTION to Dismiss . filed by Anthem Healthchoice Assurance, Inc. For the above reasons, the Court grants Anthem's motion to dismiss Plaintiffs' claims with prejudice. The Clerk of Court is respectfully directed to enter judgment in Anthem's favor and to close this case. SO ORDERED. (Signed by Judge John P. Cronan on 3/2/2026) (ar) Transmission to Orders and Judgments Clerk for processing. (Entered: 03/02/2026)
03/05/2026	32	CLERK'S JUDGMENT re: 31 Memorandum & Opinion in favor of Anthem Healthchoice Assurance, Inc. against Jane Doe, Patricia Cavallaro-Kearins. It is hereby ORDERED, ADJUDGED AND DECREED: That for the reasons stated in the Court's Opinion and Order dated March 2, 2026, the Court has granted Anthem's motion to dismiss Plaintiffs' claims with prejudice; accordingly, the case is closed. (Signed by Clerk of Court Tammi M Hellwig on 3/5/2026) (Attachments: # 1 Appeal Package) (km) (Entered: 03/05/2026)
03/31/2026	33	NOTICE OF APPEAL from 32 Clerk's Judgment,,. Document filed by Patricia Cavallaro-Kearins, Jane Doe. Filing fee $ 605.00, receipt number ANYSDC-32628970. Form C and Form D are due within 14 days to the Court of Appeals, Second Circuit..(Gardener, Jacob) Modified on 3/31/2026 (nd). (Entered: 03/31/2026)
03/31/2026		Transmission of Notice of Appeal and Certified Copy of Docket Sheet to US Court of Appeals re: 33 Notice of Appeal,..(nd) (Entered: 03/31/2026)
03/31/2026		Appeal Record Sent to USCA (Electronic File). Certified Indexed record on Appeal Electronic Files for 33 Notice of Appeal, filed by Patricia Cavallaro-Kearins, Jane Doe were transmitted to the U.S. Court of Appeals..(nd) (Entered: 03/31/2026)

PACER Service Center

Transaction Receipt

07/02/2026 11:00:42

PACER Login:	cpnycpara16	**Client Code:**	
Description:	Docket Report	**Search Criteria:**	1:24-cv-08012-JPC
Billable Pages:	7	**Cost:**	0.70

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JANE DOE on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS; and ANTHEM HP, LLC, d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD HP, and d/b/a ANTHEM BLUE CROSS HP,

Defendant.

Case No. _____

CLASS ACTION COMPLAINT

JURY TRIAL DEMANDED

Plaintiffs Jane Doe on behalf of her child Baby Doe, a minor, and Patricia Cavallaro-Kearins bring this class action for damages, equitable relief, and injunctive relief against Anthem HealthChoice Assurance, Inc., d/b/a Anthem Blue Cross and Blue Shield and d/b/a Anthem Blue Cross; and Anthem HP, LLC, d/b/a Anthem Blue Cross and Blue Shield HP and d/b/a Anthem Blue Cross HP (collectively referred to herein as "Defendant" or "Anthem"). Plaintiffs allege the following based upon personal information as to allegations regarding themselves, on their own investigation, and on the investigation of their counsel, and on information and belief as to all other allegations.

NATURE OF THE ACTION

1. There is a mental health crisis in this country and in this state. It is afflicting men and women, children and adults, and people of all income levels and backgrounds. And it is exacerbated by health insurance companies, like the Defendant, that mislead people in need of qualified providers by publishing grossly inaccurate directories of doctors and therapists. These

inaccurate directories – which purport to list qualified professionals who are supposedly in-network with Defendant but are not – are known as "ghost networks."

2. "Ghost networks" are directories provided by health insurers that list health care providers that purportedly are in-network with their insurance plan, but in reality are not. These ghost networks are also replete with errors and duplications, which make them inaccurate, incomplete, deceptive, and misleading. Mental health provider directories are more likely than those in any other medical specialty to be ghost networks.

3. The Defendant's publication of an inaccurate provider directory is not just an inconvenience for people searching for mental health providers; it is far more insidious and costly. By publishing an inaccurate provider directory where the vast majority of doctors listed – more than 80% – either don't exist, are listed with non-working telephone numbers, or are listed with inaccurate telephone numbers – making them virtually impossible to contact – or are not actually in-network with Defendant, the Defendant did not just mislead people, but damaged them.

4. These damages are not just financial but often contribute to exacerbating patients' mental health problems. The people using the Defendant's provider directory are often desperate for mental health care for themselves, for their children, and for their loved ones. And the inaccurate provider directory actually causes harm. Some patients, like the Plaintiffs, have had their treatment delayed. Many, like the Plaintiffs, have had to utilize out-of-network doctors and as a result have incurred thousands of dollars in mental health medical expenses.

5. Other patients have abandoned their search for care, resulting in serious mental health consequences and complications.

6. Mental health care is supposed to be covered by the Defendant's insurance policy. In reality, it is not: there are almost no mental health providers in New York who actually accept the Defendant's insurance, who are "in network," and who accept new patients. And thus, the promised coverage is largely illusory. When there are very few – or no – doctors who are in-network with Defendant – or when doctors are in-network but are not within a reasonable distance – such a network not only violates the law, regulations, standards, and guidance, it fails the network adequacy common sense smell test.

7. The Defendant knowingly publishes an inaccurate provider directory; and it does so for several reasons.

8. First, the Defendant publishes an inaccurate and misleading directory – which contains thousands of providers who supposedly participate in the Defendant's network but do not – in order to attract potential customers. The Plaintiffs, and other members of the proposed class, are participants in the Federal Employees Health Benefits ("FEHB") Program. As such, they – and every other federal employee eligible for the FEHB – have multiple health insurance plan options. The Defendant competes against these other providers and does so by advertising benefits of its particular plans. And by publishing a seemingly robust, if secretly inaccurate, directory of participating providers, the Defendant is knowingly engaging in a deceptive advertising campaign intended to lure people – like the Plaintiffs – into choosing one of its plans.

9. Second, by publishing a seemingly robust – but inaccurate – directory of providers, the Defendant is deceptively trying to appear to comply with federal requirements that its offered plans have an adequate network of providers who actually accept the Defendant's insurance.

10. The Defendant's promise of an adequate network of qualified providers is deceptive advertising. The listings are inaccurate in numerous ways: some are listings of doctors

who don't exist. Others are listed with inaccurate or non-working telephone numbers – making them impossible to reach. Many of the doctors listed are not part of Defendant's network. Some of the listings include incorrect specialties for the doctor. In sum, these are deceptive business practices on the part of the Defendant.

11. By publishing telephone numbers that are inaccurate, the Defendant sends patients on a wild goose chase searching for doctors covered by their plan. The time spent reaching wrong numbers or encountering non-working numbers is not just valuable time wasted, it is discouraging and contributes to patients abandoning their search for care. For people seeking mental health care for themselves or their children, this wild goose chase for in-network doctors is not small potatoes; it is a time-consuming, exhausting, frustrating experience that is detrimental to their mental health.

12. Grossly inaccurate listings in a directory – and a directory essential for directing patients to needed medical care – are a violation of the federal No Surprises Act, the federal Mental Health Parity and Addiction Equity Act, the Defendant's contractual obligations to Plaintiffs, New York General Business Law §§ 349 and 350, New York Insurance Law § 4226, and the New York State Department of Financial Services' standards and guidance.

13. The Plaintiffs – and other members of the proposed class – have suffered real injury and damages. The Plaintiffs have paid premiums for the Defendant's insurance plan for coverage that never existed or was grossly inadequate. The Defendant has failed to provide an adequate network of mental health providers who actually accept the Defendant's insurance or offer appropriate types of care. The Plaintiffs also suffered significant financial damage by having to pay thousands of dollars for out-of-network providers because there were no qualified in-network providers within a reasonable travel radius. The Plaintiffs also wasted time and were

frustrated by having to spend countless hours calling providers who the Defendant represented as being qualified and participating in the Defendant's network, only to find out that the phone numbers listed by the Defendant were wrong, that the providers did not offer the services listed in the Defendant's provider directory, were not qualified, or did not participate in the Defendant's network.

JURISDICTION AND VENUE

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

15. This Court has personal jurisdiction over the Defendant because it can be found, resides, and/or transacts business in New York State, and it is headquartered in the State of New York and regularly conducts business in New York County.

16. Venue is proper in this Judicial District pursuant to 28 U.S.C. § 1391(b). The Defendant is a resident of and headquartered in this Judicial District, it conducts business in this Judicial District, and a significant portion of its activities took place within this Judicial District.

THE PARTIES

I. Plaintiffs

17. Plaintiff **Jane Doe** is a resident of New York. She has been a member of the Standard Option Plan for more than five years.

18. Ms. Doe is the mother of 8-year-old **Baby Doe** who has been covered by the Standard Option Plan for more than five years.

19. Plaintiff **Patricia Cavallaro-Kearins** is a resident of New York. She has been a member of the Anthem health insurance plan known as the Blue Cross Blue Shield Service Benefit Plan FEP Blue Standard Option ("Standard Option Plan") since January 1, 2019.

II. Defendant

20. Defendant Anthem is a health insurance company licensed to do business in New York. It is one of multiple health insurance companies with plans that are offered to federal employees under the Federal Employees Health Benefits ("FEHB") Program.

21. In New York, Defendant operates under several different entities and under various trade names. Anthem HealthChoice Assurance, Inc. operates under the trade name Anthem Blue Cross and Blue Shield in 17 southeastern counties. Anthem HP, LLC operates under the trade name Anthem Blue Cross in 11 northeastern counties in New York.

22. Prior to changing its name to Anthem HealthChoice HMO, Inc. in 2024, it operated as Empire HealthChoice Assurance, Inc.; and before that, as Empire HealthChoice Inc; and before that, as Empire Blue Cross and Blue Shield. Its website is www.empireblue.com, which when clicked brings the user to www.anthembluecross.com. These older names are relevant to this complaint because some people, providers, and materials still refer to "Empire."

BACKGROUND & CONTEXT

I. The Mental Health Crisis in America

A. The Adult Mental Health Crisis

23. There is a mental health crisis in the United States. According to the National Institute Mental Health National Survey on Drug Use and Health by the Substance Abuse and Mental Health Service Administration of 2021, there were an estimated 57.8 million adults in the U.S. with a mental illness. That is 22.8% of U.S. adults.[1]

24. Younger adults reported a higher prevalence of mental health problems:

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

- Ages 18–25: 33.7% of adults reported having a mental illness.
- Ages 26–49: 28.1% of adults reported having a mental illness.
- Ages 50+: 15.0% of adults reported having a mental illness.

25. Some 52.8% of the 57.8 million adults with any mental illness did not receive mental health services within the previous year.[2]

26. Treatment rates for adults aged 18–25 were lower than for all other adults: some 55.4% of the age group went without treatment.[3]

27. In 2021, an estimated 14.1 million adults in the U.S. had a *serious* mental illness, some 5.5% of the population.[4]

28. In total, 34.6% of those with serious mental illness did not receive mental health services.[5]

B. The Child Mental Health Crisis

29. According to the Centers for Disease Control and Prevention ("CDC"), among adolescents aged 12 to 17 years old:[6]

- 15.1 percent have had a major depressive episode.
- 36.7 percent have had persistent feelings of sadness or hopelessness.
- 4.1 percent have had a substance use disorder.

---

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

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

- 1.6 percent have had an alcohol use disorder.
- 3.2 percent have had an illicit drug use disorder.
- 18.8 percent seriously considered attempting suicide.
- 15.7 percent made a suicide plan.
- 8.9 percent attempted suicide.
- 2.5 percent made a suicide attempt requiring medical treatment.

30. The situation is so acute that the Surgeon General of the United States has described mental health as "the defining public health crisis of our time," and warned of the "devastating effects" of mental health challenges on young people.[7] This came as the suicide rate for young Americans jumped by 57 percent from 2001 to 2018, and pediatric visits for self-harm rose by 329 percent from 2007 to 2016.[8] The Surgeon General released a rare Advisory[9] titled *Protecting Youth Mental Health* urging that "every child ha[ve] access to high-quality, affordable, and culturally competent mental health care."[10]

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

[8] 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/.

[9] "A Surgeon General's Advisory is a public statement that calls the American people's attention to an urgent public health issue … . Advisories are reserved for significant public health challenges that need the nation's immediate awareness and action." *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, Off. of the Surgeon Gen. (2021), https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[10] *Id.*

31. Compounding this crisis are serious barriers to accessing needed mental health treatment. The CDC estimates that of the 1 in 5 children who have a mental, emotional, or behavioral disorder, only approximately 20 percent receive care from a mental health provider.[11]

32. Non-white and uninsured children are even less likely to receive mental health care treatment.[12] In New York City, the disparate impact is great, with only approximately 11 percent of Asian American and Pacific Islander children reporting being connected to mental health care, 19 percent of Black children, and 20 percent of Latinx children.[13]

33. The consequences of untreated mental illness in children and adolescents are profound and are associated with school failure, teenage pregnancy, unstable employment, substance use, violence including suicide and homicide, and poor medical outcomes.[14]

C. The Mental Health Crisis in New York

34. According to Mental Health America, in 2022, an estimated 19.5% of adults in New York, approximately 2,972,000 people, suffered from a mental illness.[15]

---

[11] Ctrs. for Disease Control and Prevention, *Improving Access to Care, Children's Mental Health*, Children's Mental Health, https://www.cdc.gov/childrensmentalhealth/access.html

[12] *Mental Health Data Dashboard*, NYC Mayor's Off. of Cmty Mental Health, https://mentalhealth.cityofnewyork.us/dashboard/; *see also* Janet Cummings et al., *Geographic Access to Specialty Mental Health Care Across High-and Low-Income US Communities*, JAMS Psychiatry, (May 2017), https://pubmed.ncbi.nlm.nih.gov/28384733/ ("When examining the distribution of mental health professionals, 25.3% of the communities (2014 of 7959) in the highest income quartile had a mental health specialist physician practice vs 8.0% (637 of 7959) of those in the lowest income quartile… .").

[13] *Mental Health Data Dashboard*, supra note 12. These figures represent high school students who got help from a professional counselor, social worker, or therapist for an emotional or personal issue in the last 12 months.

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

[15] Mental Health America, *Adult Data 2022*, https://www.mhanational.org/issues/2022/mental-

(continued…)

35. According to the Kaiser Family Fund mental health survey of 2023:

- 28.8% of New York adults reported symptoms of anxiety disorder.
- 19.4% of New York adults reported symptoms of depressive disorder.
- 31.4% of New York adults reported symptoms of anxiety or depressive disorder.[16]

II. Federal and State Requirements of Health Insurers

A. Federal and New York State Law Impose Additional Obligations on Health Plans to Ensure Accuracy of Provider Directories

36. As discussed above, the federal government has expressed serious concern about the prevalence of ghost networks and the significant barriers they create to mental health care. In addition to the congressional inquiries and hearings, federal and state laws and regulations have been promulgated in an effort to protect consumers from the harms of ghost networks.

37. In 2022, Congress passed the federal No Surprises Act, which includes a section entitled "Protecting Patients and Improving the Accuracy of Provider Directory Information" that establishes requirements for provider directories to help protect consumers from surprise bills from out-of-network providers.[17]

38. The No Surprises Act requires health plans to publish and maintain accurate provider directories; specifically, insurance companies must update and verify their plans'

---

health-america-adult-data#six.

[16] KFF, *Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic*, https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[17] Pub. L. No. 116-260, 134 Stat. 1182, Division BB, (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text; adding 42 U.S.C. § 300gg, 29 U.S.C. § 1185i, and 26 U.S.C. § 9820.

provider directories at least every 90 days.[18] Where plans are unable to verify provider data, they must establish a procedure to remove providers from their directories.[19] Health plans must also update provider information within two days of receiving an update from a provider.[20]

39. The law also imposes obligations on health insurers directly towards their members. When a member requests information about whether a provider is in-network, the plan must respond within one day of the request.[21] And where a member relies on inaccurate provider directory information and mistakenly receives services from an out-of-network provider, the member will not be responsible for cost sharing greater than in-network cost sharing.[22]

40. A health plan is also required to remove providers where it cannot verify the provider's status, independently of provider obligations.[23]

41. New York State passed its own no-surprises law in 2015, which also requires health plans to ensure the accuracy of their provider directories. Under New York law, health insurers are required to update their provider directories within an even shorter time period – within 15 days of the "addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation" – and otherwise update their plans' directories

[18] 42 U.S.C. § 300gg-115(a)(2)(A).

[19] 42 U.S.C. § 300gg-115(a)(2)(B), (C).

[20] *Id.*

[21] 42 U.S.C. § 300gg-115(a)(3)(A), (B).

[22] 42 U.S.C. § 300gg-115(b)(1)(A), (B).

[23] In addition, the terms of the contract between provider and plan may require the plan to remove the provider if the contract terminates.

annually.[24] State law also requires health plans to include in their directories whether a provider is accepting new patients and any restrictions on a provider's availability.[25]

42. Since state laws are not pre-empted by the No Surprises Act,[26] and as made clear by New York's Department of Financial Services, health plans in New York are still required to update their directories within 15 days of a provider change.[27]

43. These federal and state laws reflect governments' recognition of the harmful consequences of inaccurate provider directories. Despite these legislative efforts to shield consumers from ghost networks, surprise bills, and inadequate in-network care, insurance companies in general, and the Defendant in particular, continue to violate these laws.[28]

[24] N.Y. Ins. Law § 3217-A(a)(17).

[25] *Id.*

[26] "Nothing in this section shall be construed to preempt any provision of state law relating to health care provider directories." 42 U.S.C. § 300gg-139(e).

[27] NYS Dept. Fin, Insurance Circ. Ltr, No. 12 (Dec. 29, 2021), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_12 ("[T]he NSA does not preempt any provision of state law relating to health care provider directories. Insurance Law §§ 3217-a(a)(17) and 4324(a)(17) and Public Health Law § 4408(1)(r) require an issuer to annually update its provider directory, with certain updates to the provider directory on the issuer's website completed within 15 days as described above. The Insurance Law and Public Health Law requirements for provider directory content and updates within 15 days continue to apply at this time.").

[28] *See, e.g.*, Neel M. Butala et al., *Research Letter: Consistency of Physician Data Across Health Insurer Directories*, JAMA 329(10), 842 (Mar. 14, 2023), https://jamanetwork.com/journals/jama/article-abstract/2802329 (finding even after passage of No Surprises Act that "[i]n examining directory entries for more than 40% of US physicians, inconsistencies were found in 81% of entries across 5 large national health insurers").

B. Federal and New York State Law Require Health Plans to Ensure Sufficient In-Network Mental Health Providers

44. There is an additional set of federal and state laws implicated by inaccurate provider directories: "network adequacy" laws require that health plans offer a network that includes a "sufficient" number of in-network providers.

45. The Affordable Care Act first established this "network adequacy" framework, requiring that all qualified health plans[29] ensure the provision of a network that is "sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay."[30]

46. New York State adopted this standard and applied it broadly to a majority of health plans offered in the state. New York law requires health plans to "ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract."[31]

47. Specifically, New York guidance provides "preferred time and distance standards," advising that mental health providers should be accessible within 30 minutes by public transportation and/or 30 miles by car.[32] The guidance also states that, "to be considered accessible, the network should contain a sufficient number and array of providers to meet the diverse needs of the insured population and to ensure that all services will be accessible without

[29] "Qualified health plans" are plans sold on a state or federal exchange. 42 U.S.C. § 18021.

[30] 45 C.F.R. § 156.230.

[31] N.Y. Ins. Law § 3241(a).

[32] *See Network Adequacy Standards and Guidance*, N.Y. State Dep't of Fin. Servs., https://www.dfs.ny.gov/apps_and_licensing/health_insurers/nyoon_law_guidance_questions_federal_ns_act.

undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities."[33]

48. The Defendant is in violation of federal law requiring network adequacy.

49. As discussed below, a significant collateral consequence of an inaccurate, inflated provider directory is that an insurance plan appears to meet network adequacy requirements, when it does not.

50. This, too, was highlighted during the recent Senate Finance Committee hearing:[34]

> SENATOR WARREN: Do these ... plans stand to gain anything from having inaccurate information? In other words, is it inaccurate because you just haven't spent enough money to make it accurate, or is it inaccurate by design?
>
> MS. GILIBERTI (the Chief Public Policy Officer of Mental Health America): Well, I think there are advantages they have when their directories are unfortunately inaccurate. They use those directories for network adequacy standards.[35]

III. Ghost Networks

A. The United States Senate Finance Committee Ghost Networks Hearings

51. In May 2023, the United States Senate Finance Committee held a hearing on this exact topic, titled "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks."[36] One testifying witness, a former official in the

---

[33] *Id.*

[34] This exchange focused on Medicare Advantage plans in particular, but it would apply to many other health plans.

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

[36] *See id.*

Obama Administration, summarized her Sisyphean experience trying to find a mental health provider through her insurance plan's directory:

> I was left to navigate the … provider directory to find a psychiatrist. Calling psychiatrists within D.C. and Maryland, selected out of what was like a digital white-pages phone book, turned into one rejection after another. Call after call resulted in the following types of responses:
>
> > "Who? Hmm, s/he doesn't work here. No, I don't know where s/he works now."
> >
> > "Who? I don't know who that is, not sure they ever worked here. Hold please ... . [dial tone]."
> >
> > Recorded message: "Dr _____ is no longer accepting new patients. If this is an emergency, hang up and call 911."
>
> I spent countless days and hours scouring the network, despite working long hours in a high-level management position. When was there time to find a psychiatrist? I had to make the time, though, as my job, and more importantly my life, depended on it. Continued attempts finally led me to a psychiatrist who was taking new patients. Success, though, was short-lived. In our phone conversation to set up an initial in-person appointment, I was asked about my diagnosis. I had no worry or fear; this doctor, this psychiatrist, was taking new patients. I respond without hesitation – schizophrenia. A pause, a long silence ... and then the response:
>
> > "Oh....I do not take patients with a schizophrenia diagnosis."
>
> I ask if they have any suggestions or referrals to help me find a doctor who does. The answer is:
>
> > "Check the provider directory."[37]

52. The prevalence, and degree, of ghost networks of mental health providers is nothing short of astonishing. A study recently conducted by the Senate Finance Committee majority staff reviewed 12 different directories across six states and were only able to make

[37] *Id.* (Testimony of Keris Jän Myrick).

appointments with 18 percent of the mental health providers contacted[38] – i.e., over 80 percent of the listed in-network providers were in reality "either unreachable, not accepting new patients, or not in-network."[39] For one state, no successful appointments could be made.[40] Another study from 2015 resulted in an appointment with a psychiatrist only 26 percent of the time.[41]

53. Almost all people seeking a mental health provider on a ghost network spend countless, difficult hours searching for care.[42] This is dangerously exacerbated by the fact that the person may be experiencing a mental health emergency. As explained by Dr. Robert Trestman, representing the American Psychiatric Association, at the Senate Finance Committee hearing:

> For those who are healthy and well educated, going through an inaccurate provider list and being told repeatedly that "we are not taking new patients," "this provider has retired," "we no longer accept your insurance," or leaving a message with no one returning the call is at best frustrating. For people who are experiencing significant mental illness or substance use disorders, the process of going through an inaccurate provider directory to find an appointment with someone who can help them 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. Patients have told me that they felt rejected repeatedly or that somehow they themselves were at fault. Even when they make the effort to reach

[38] *Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks*, Senate Comm. on Finance (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323 Ghost Network Hearing - Secret Shopper Study Report.pdf [*hereinafter* Secret Shopper Study Report].

[39] *Id.* at 1.

[40] *Id.* at 7.

[41] 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.

[42] In the study conducted by the Senate Finance Committee majority staff, "[c]all times ranged from 1-3 hours to contact 10 listings per plan." *See* Secret Shopper Study Report, *supra* note 38.

> out to find help, something that can be very difficult anyway, their efforts to cull through an inaccurate provider list results in more rejection and failure, exacerbating these feelings. Some give up looking for care. Others delay care.[43]

54. At the same hearing, Senator Thom Tillis spoke of his own personal experience seeking care when suffering from mental illness:

> Back in 2007, I was diagnosed with an illness that required me to take medications that caused me to have pharmacologically induced mania followed by clinical depression, so I got a window into mental health that I consider to be a blessing … . When I'm in mania[,] I simply would not have sought a health care or a behavioral health professional. And when I was in depression, if I went to a website and went through [the provider directory], I'd have said what's the use. So we need to understand this has real life consequences. And you're in the worst possible state to have the complexity, and maybe even in the middle of depression, finding out that you have to pay out of network costs, so now you've got financial stressors, you've got whatever the underlying condition is, the insurers and providers, everybody needs to understand that.[44]

55. The government's findings described above are disturbing, and the barriers to mental health care caused by ghost networks are devastating. Obstructions to treatment manifest in several ways. Because people in need are unable to find a mental health provider covered by their insurance on their plan's provider directory, urgent mental health treatment is often delayed and, at worst, abandoned completely. Others seeking care rely on the directory to find a provider, only to find out later that the provider is not covered by their plan, and so they are subject to significant, unexpected costs. And, in other cases, people urgently seeking care knowingly settle for seeing an out-of-network provider because they desperately need help, and it is their only option. They are left to figure out how to shoulder the often-exorbitant costs that follow.

---

[43] Senate Hearings on Mental Health Care, *supra* note 35 (Testimony of Robert L. Trestman, PhD, MD).

[44] Senate Hearings on Mental Health Care, *supra* note 35 (Testimony of Senator Thom Thillis).

56. Yet another consequence of a ghost network is that individuals selecting an insurance plan in the first place may incorrectly choose that plan either because the provider they already see is listed on the plan's directory or because there appears to be a robust network of potential providers. The plan's ghost network is the enticement: but for a plan's ghost network, consumers may have made different health care and financial decisions.

57. Though the effects of ghost networks are far-reaching and complex, the wrongful conduct at issue is simple: insurance companies' ghost networks mislead consumers to buy health plans that they say include a network of providers when they do not. As Senator and Chairman of the Senate Finance Committee Ron Wyden stated in his opening remarks at the Senate's hearing on ghost networks, insurance companies are at fault and their wrongdoing is clear:

> [W]hen insurance companies host ghost networks, they are selling health coverage under false pretenses, because the mental health providers advertised in their plan directories aren't picking up the phone or taking new patients. In any other business, if a product or service doesn't meet expectations, consumers can ask for a refund….
>
> In a moment of national crisis about mental health, with the problem growing exponentially during the pandemic, the widespread existence of ghost networks is unacceptable. When someone who's worried about their mental health or the mental health of a loved one finally works up the courage to pick up the phone and try and get help, the last thing they need is a symphony of "please hold" music, non-working numbers, and rejection.
>
> Just take a moment and think about the impact that might have on an individual who's already in a challenging situation. It's not hard to imagine how many Americans simply give up and go on struggling without the help they need….
>
> I want to conclude by talking about accountability. My view is that insurance companies have gotten a free pass for too long letting ghost networks run rampant. If a student were writing an essay and 80 percent of their citations were incorrect or made up, they'd receive an "F." If a business gave the SEC false or incorrect information, it would face extremely severe consequences. So in my view insurance companies

> should face strict consequences if their products don't live up to the billing. That's the least that should be done….[45]

B. The New York Attorney General's Study

58. In December 2023, the New York State Office of the Attorney General ("OAG") issued a report entitled, "Inaccurate and Inadequate: Health plans' mental health provider network directories." This report was an overview of the provider directories provided by the health insurance companies operating in New York, including Defendant Anthem.[46]

59. According to the report, the OAG "surveyed nearly 400 mental health providers listed on health plans' networks and found that the overwhelming majority, 86 percent, were 'ghosts,' meaning they were unreachable, not-in-network, or not accepting new patients. Inaccurate network directories are worsening the statewide mental health crisis and disproportionately impact marginalized communities, leading to adverse health outcomes, and increasing costs for patients."[47]

60. The OAG stated:

> New Yorkers struggling with mental health conditions rely on health plan provider directories to access affordable, quality health care services. However, when provider directories contain inaccurate listings or unavailable providers – known as ghost networks – patients may be unable to access treatment using their

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

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

[47] Press Release, *Attorney General James Uncovers Major Problems Accessing Mental Health Care through Insurance Companies* (Dec. 7, 2023), https://ag.ny.gov/press-release/2023/attorney-general-james-uncovers-major-problems-accessing-mental-health-care.

health insurance benefits. As a result, they are forced to choose between paying out-of-pocket, which is not possible for many, or forgoing treatment altogether.[48]

C. The OAG's Secret Shopper Survey of Defendant Anthem

61. Defendant Anthem was one of 13 health providers in New York that were the subject of the OAG's investigation.

62. The OAG tried to reach 13 mental health providers for adults who are supposedly in the Anthem plan's network. The OAG found that only five were actually in-network; and of those, the OAG was only able to make in-person appointments at two. The OAG concluded that the "ghost percentage" of Defendant Anthem for adults was 67%.

63. The OAG's findings for providers who treated children was even worse. The OAG called seven providers who were supposedly in-network with the Anthem plan and treated children. Only four of the seven were actually in-network; and the OAG was not able to make an appointment with any of them. The OAG reported Anthem as having an abysmal 100% ghost network for children.

D. Additional Investigations of Ghost Networks

64. On a national scale, the issue of ghost networks and their attendant harms to consumers at large has been reported by *The New York Times*,[49] *The Washington Post*,[50] and many other significant publications.[51]

---

[48] *Id.*

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

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

[51] *See, e.g.*, Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan*
(continued…)

65. The American Medical Association co-authored a white paper on some of the financial and non-financial injuries from ghost networks:

> When directory information is inaccurate, patients experience inconvenience (non-working phone numbers, longer time to find the right practitioner), and financial consequences (unplanned out of pocket expenses). Directory errors may also result in a patient selecting a health plan based on inaccurate information about which clinicians are in-network.[52]

66. A March 2022 report by the United States Government Accountability Office corroborated the findings outlined above, concluding that "consumers with coverage for mental health care experience challenges finding in-network providers[,]"[53] and that "[i]naccurate or out-of-date information on which mental health providers are in a health plan's network contributes to ongoing access issues for consumers and may lead consumers to obtain out-of-network care at higher costs to find a provider."[54]

67. The federal Centers for Medicare & Medicaid Services similarly identified network directory inaccuracies, including those "with the highest likelihood of preventing access to care."[55]

Provider Directories, 40 Yale L. & Pol'y Rev. 78, 85 (2021).

[52] *Improving Health Plan Provider Directories*, CAQH & Am. Med. Ass'n., 3, https://www.caqh.org/sites/default/files/other/CAQH-AMA_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf ("Among the more common resources that patients use are health plan provider directories which, according to two surveys conducted in 2020, more than half of patients use to select a physician.") (citations omitted).

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

[54] *Id.* at 12.

[55] *Online Provider Directory Review Report*, Ctrs. for Medicare & Medicaid Servs., 1, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/

(continued…)

68. In a study of adolescent psychiatrists in particular, researchers posing as parents seeking care for a child with depression were only able to obtain an appointment 17 percent of the time.[56]

69. The crisis in access to mental health treatment is exacerbated by barriers to care imposed by health insurance companies, including the prevalence of ghost networks.[57]

FACTUAL ALLEGATIONS

I. Plaintiffs' Needs for Mental Health Care

A. Ms. Cavallaro-Kearins

70. Plaintiff Patricia Cavallaro-Kearins is a resident of New York. She has been a member of the Anthem health insurance plan known as the Blue Cross Blue Shield Service Benefit Plan FEP Blue Standard Option ("Standard Option Plan") since January 1, 2019. Ms. Cavallaro-Kearins has paid a monthly premium of $571.63 for the Anthem Standard Option plan since her enrollment and has spent thousands of dollars on those premiums.

Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.

[56] Shireen Cama et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, Int'l J. Health Serv. 47(4) (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/ (studying availability of outpatient pediatrician and child psychiatry availability and finding that "[a]ppointments were obtained with 40% of the pediatricians and 17% of the child psychiatrists. The mean wait time for psychiatry appointments was 30 days longer than for pediatric appointments. Providers were less likely to have available appointments for children on Medicaid.").

[57] *See, e.g.*, Katherine Ellison, *73 doctors and none available: How ghost networks hamper mental health care*, WASH. POST (Feb. 19, 2022), https://www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network/; Jack Turban, *Ghost networks of psychiatrists make money for insurance companies but hinder patients' access to care*, State News (June 17, 2019), https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/ ("The numbers, however, never seem as bad for other specialties as they do for psychiatry.").

71. Ms. Cavallaro-Kearins relied on Anthem's representations – through its online advertising, its website, its online directory, and other Anthem resources – when choosing which health insurance plan to enroll in, and in utilizing the plan. These resources include Anthem's "Benefits at a Glance,"[58] the "Benefit Summary Book,"[59] the "Service Benefit Plan"[60] (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource.[61] She specifically relied on Anthem's representations that it offered an adequate network of mental health providers.

72. Ms. Cavallaro-Kearins has been medically diagnosed with attention deficient hyperactivity disorder ("ADHD"). She requires mental health care and pharmaceutical drugs to treat her condition.

73. In 2020, with the onset of the COVID-19 pandemic, Ms. Cavallaro-Kearins' ADHD was worsening and coupled with increasing anxiety. She decided that she must seek care for both her anxiety and ADHD. Because ADHD medications are controlled substances, the care had to be provided by a provider licensed to prescribe such medication such as a psychiatrist or other medical doctor.

---

[58] Blue Cross Blue Shield Federal Employee Program, *2024 Benefits At A Glance*, www.fepblue.org/-/media/PDFs/Brochures/508-2024-Benefits-at-aGlance.pdf [hereinafter *Benefits at a Glance*].

[59] Blue Cross Blue Shield Federal Employee Program, *2024 Benefit Summary Book*, www.fepblue.org/-/media/PDFs/Brochures/2024/508_2024_BenefitSummaryBook_interactive.pdf [hereinafter *Benefit Summary Book*].

[60] Blue Cross Blue Shield Federal Employee Program, *Blue Cross and Blue Shield Service Benefit Plan (FEP Blue Standard and FEP Blue Basic Option)*, www.fepblue.org/-/media/PDFs/Brochures/Standard-and-Basic-Option-brochure-2024.pdf [hereinafter *Brochure*].

[61] Blue Cross Blue Shield Federal Employee Program, *Find A Doctor*, https://www.fepblue.org/find-doctor.

74. As advertised by her insurance plan and as she would with other health care, Ms. Cavallaro-Kearins turned to her insurance's online provider directory of in-network providers to find a psychiatrist. She began to call providers. She repeatedly found that many providers included in the directory were listed with inaccurate telephone numbers – making it impossible to reach them; others did not practice the specialties listed for them in the directory; and many simply did not accept her Anthem insurance. She spent hours, days, and months calling providers and could not find a single available, in-network provider using Anthem's online provider directory.

75. Frustrated, but determined to find care, she reached out to Anthem not once, but twice to ask for an updated list of in-network providers. Ms. Cavallaro-Kearins began calling providers on those lists. And once again, she was unable to find an available in-network provider.

76. The inaccurate provider directory delayed her treatment and left her with two options: forgoing essential medical care or paying out of pocket for treatment. She needed the care and had to resort to paying out of pocket for out-of-network providers because there were no in-network providers within a reasonable distance of her home. Ms. Cavallaro-Kearins had to spend thousands of dollars on out-of-network providers. And the reimbursement from Anthem was a tiny fraction of her out-of-pocket costs.

77. Ms. Cavallaro-Kearins first turned to "Done.," an online ADHD assessment and prescription service. She used "Done." for multiple months paying a monthly subscription for her medication management.

78. However, this treatment was not sufficient to address her ongoing anxiety and she wanted to be seen regularly by a physician for her ADHD and related medication management.

79. She once again turned to Anthem's online provider directory and was again unable to find an available in-network provider. She was again left with no other option than to go out-of-network.

80. In September 2021, Ms. Cavallaro-Kearins began seeing an out-of-network provider, paying $240 a week out-of-pocket and upfront. From September 2021 to February 2022, she paid $240 a week and had to mail the requests for reimbursement. On numerous occasions, Anthem responded to her requests by saying that it never received the requests for reimbursements. Two to three times Ms. Cavallaro-Kearins had to mail in the statements, increasing her anxiety, stress, and frustration while paying out of pocket for mental health services that should have been covered by her insurance to begin with.

81. Because of the significant out-of-pocket expense of being treated by an out-of-network provider, Ms. Cavallaro-Kearins continued to try to use Defendant's directory throughout the period of October 2021 through February 2022 and to the present to try to find in-network providers. Throughout this period from October 2021 through the present, Ms. Cavallaro-Kearins found the Defendant's provider directory to be grossly inaccurate.

82. She needed the care, but the out-of-network costs were not sustainable. For this reason, Ms. Cavallaro-Kearins stopped going to the out-of-network psychiatrist.

83. When she had to stop treatment, she turned to the provider directory again, and was yet again unable to find an available, in-network provider. Periodically – holding on to hope that Anthem may have finally posted an accurate directory and driven by essential need for treatment – she picked up the phone and began calling from the list. But she has yet to find an available, in-network doctor using Anthem's provider directory.

84. She has been unable to find a psychiatrist in-network, and only recently was able to find and see an in-network nurse practitioner.

B. Baby Doe

85. Plaintiff Jane Doe is a resident of New York and the mother of 8-year-old Baby Doe. Both Jane Doe and Baby Doe have been enrolled in the Standard Option Plan for more than five years.

86. Ms. Doe has paid a monthly premium for the Standard Option Plan since her enrollment, and she has spent thousands of dollars on those premiums.

87. Ms. Doe relied on Anthem's representations through its online advertising, its website, its online directory, and other Anthem resources when choosing which health insurance plan to enroll in, and in utilizing the plan. These resources include Anthem's "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource. She specifically relied on Anthem's representations that it offered an adequate network of in-network mental health providers.

88. Baby Doe has been diagnosed with an autism spectrum disorder and requires regular occupational, speech, and mental health treatment by qualified mental health providers.

89. Plaintiff Jane Doe started looking for essential mental health care for Baby Doe in 2018.

90. She turned to Anthem's online provider directory and began to call the listed providers using the names and numbers posted on the website.

91. She repeatedly found that the providers included in the directory were listed with inaccurate telephone numbers; did not practice the specialties listed for them in the directory; were not in-network; or did not accept her Anthem insurance. When she did find listed providers

who were in-network with the insurance, she was told that these providers were not accepting new patients, while other providers had waitlists of six months or more before they would accept her child as a new patient.

92. After hours, days, and months of calling listed "in-network" providers, Plaintiff Jane Doe was unable to find care for Baby Doe. For Baby Doe, there were no in-network providers with the training or experience necessary to provide adequate care within a reasonable distance of her home.

93. Jane Doe was unable to financially afford out-of-network care. She had to forgo care for Baby Doe.

94. Since 2018 and continuing through the present, she has regularly returned to the provider directory and called listed providers to no avail. It is both frustrating and discouraging every time Jane Doe turns to the provider directory and is unable to find care for Baby Doe.

95. In late 2023, Jane Doe was able to secure a waitlist spot for one provider. The provider's waitlist was six months long. Jane Doe has not yet heard from the practice that it has an available appointment and accepts the insurance.

96. In short, Ms. Doe could not find an in-network doctor to treat her child at the time the child needed care. Baby Doe never received mental health care because her mother could not find an appropriate in-network doctor.

II. Anthem's Health Insurance Plans

A. Plan Options

97. Anthem is one of the largest health insurance providers in New York State. It is owned by Elevance Health, one of the largest health insurance companies in the United States. Anthem serves over a million individuals in New York State and offers multiple health insurance plans in the State.

98. Federal employees eligible for the FEHP benefits have a choice of approximately 37 different insurance plans offered by 14 different insurance companies.[62]

99. Anthem is one of the authorized health insurance companies offering plans to federal employees under the FEHP. It serves more than 150,000 federal employees and their eligible family members in New York State.

100. Anthem offers three plans to federal employees in New York State: FEP Blue Focus, Basic Option, and Standard Option.

101. None of the three options is covered by ERISA.

102. Each of the three plans has different deductibles, co-pays, co-insurance, and premiums, discussed below, but all three options purport to include robust in-network provider networks for mental health.

103. The federal government pays approximately 72% of the monthly premium for the various plans that federal employees are eligible to enroll in under FEHP. The other 28% is paid by the individual employee. The individual and family contributions for the three Anthem plans in 2024 are represented below:

Monthly Premium, 2024			
	FEP Blue Focus	**Basic Option**	**Standard Option**
Self Only	$119.83	$207.44	$326.71
Self + One	$257.58	$517.03	$729.82
Self + Family	$283.32	$568.96	$803.14

[62] Office of Personnel Management, *2024 Plan Information for New York* (2024) https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/2024/state/ny.

104. The Anthem plans are preferred provider organization ("PPO") plans. That means they have a "network" of physicians, specialists, hospitals, laboratories, and other facilities. Anthem contracts with these providers and sets negotiated rates. In turn, these providers qualify as "in-network" providers, accept lower payments from the insurer, and agree to charge members an agreed-upon discounted amount.

105. Members of Anthem who see an in-network mental health provider on an outpatient basis pay the doctor an agreed-upon amount depending on the plan in which they are enrolled:

Payment by Patient to In-Network Mental Health Provider		
FEP Blue Focus	**Basic Option**	**Standard Option**
$10 per visit for first 10 visits	$35 co-pay	$30 co-pay

106. Each plan has slightly different deductibles.

107. Members who see providers not within Anthem's network – "out-of-network" providers – will be subjected to a variety of additional costs: some known, some unknown.

108. Most importantly, only members who have Anthem's most expensive plan – the Standard Option plan – can see an out-of-network provider and be covered by the plan in any way. That means that if a member who has the FEP Blue Focus plan or the Basic Option plan sees an out-of-network provider, that member will have to pay 100% of what the doctor charges.

109. If the member has the Standard Option plan, the member will pay something less than the doctor's full charge. That is because the member gets reimbursed a small percentage of the doctor's fee. The Defendant's out-of-network reimbursement rate is pegged to a cost it refers to as its "allowance." That allowance amount is always considerably less than what the doctor

charges. Moreover, the member does not get reimbursed the full allowed amount, but only 65% of the allowance – and that is after a $350 individual (or $750 family) deductible is met. In its plan brochure, the Defendant gives an example of how much a member might pay:

> **Under Standard Option**, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and the bill. [63]

110. Anthem's "allowance" is not discernable from its website. Thus, it is (at best) very difficult for a member to know, in advance, how much it will cost to use an out-of-network provider.

111. And for a prospective member, it is essentially impossible to know – in advance – how much that payment will be: the Defendant will not tell a prospective member what its allowance for a procedure or treatment is without a member ID number.

112. FairHealth is an unrelated, highly respected, non-profit resource that provides consumers with extensive, accurate information about the cost of health care procedures. FairHealth is not a definitive price guide, but it does provide some guidance about how much a member might pay. According to FairHealth, CPT Code G0470, a mental health visit for an established patient at a Federally Qualified Health Center near zip code 10704 (the Plaintiff's zip code) would cost $418 for an out-of-network provider.[64] And $138 is the in-network (allowed) price.

---

[63] *Brochure, supra* note 60 at 29 (this exact language also appeared in the brochures in prior years).

[64] FairHealth Consumer, *Consumers Estimate Your Healthcare Expenses*,

(continued…)

113. A member would have to lay out $418 for each visit to a mental health provider. Only members with the Standard Option Plan would receive any reimbursement when using an out-of-network provider. (Basic Option and FEP Blue Focus members receive no reimbursement.) Defendant would reimburse Standard Option members approximately $90 per visit.

114. Once the member's deductible is satisfied, the Standard Option member's out-of-pocket cost per visit would be approximately $328.

115. The member's cost for an in-network provider would be $30 (if on the Standard Option Plan) or $35 (if on the Basic Option Plan) – if she could find an in-network provider accepting new patients.

116. Thus, the net cost (per visit) to the member for using an out-of-network provider would be:

	FEP Blue Focus	**Basic Option**	**Standard Option**
Out-of-Pocket Payment Per Visit	$418	$418	$328

B. Defendant's Contract with the Office of Personnel Management

117. All of the FEHB plans offered by Anthem are governed by a contract between Anthem and the U.S. Office of Personnel Management.

118. Pursuant to U.S. Office of Personnel Management contracting requirements, the contract requires Anthem to comply with the No Surprises Act and other federal laws, including sections 2799A–1, 2799A–2, 2799A–3, 2799A-4, 2799A-5, 2799A–7, and 2799A–8 of the

https://www.fairhealthconsumer.org/.

Public Health Service Act, sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986.

119. Section 2799A-5 of the Public Health Service Act requires health insurers to verify and update their provider directory not less frequently than once every 90 days, remove a provider from the directory when it is unable to verify the directory information for that provider, and update the directory within two days of receiving new information from a provider.

120. Section 720 of the Employee Retirement Income Security Act of 1974 requires health insurers to verify and update their provider directory not less frequently than once every 90 days, remove a provider from the directory when it is unable to verify the directory information for that provider, and update the directory within two days of receiving new information from a provider.

121. Section 9820 of the Internal Revenue Code of 1986 requires health insurers to verify and update their provider directory not less frequently than once every 90 days, remove a provider from the directory when it is unable to verify the directory information for that provider, and update the directory within two days of receiving new information from a provider.

III. Defendant's Ghost Network

A. Anthem's Provider Directory

122. Anthem affirmatively tells members: "Choosing the right health plan matters. You want to make sure you have the coverage you need." Anthem further states that members "enjoy

… a network that includes over 1.7 million doctors."[65] Anthem also states, "Blue Cross Blue Shield has more doctors and hospitals in our network than any other insurer in the U.S."[66]

123. At all relevant times, the Defendant published an online directory of doctors who supposedly are in-network with the Defendant. This directory is publicly available to members and non-members of Anthem's insurance plans.

124. This online directory, for members and potential members, is the definitive resource for people to identify which providers are in Anthem's network and are thereby covered as an in-network provider.[67]

125. This directory can be sorted and searched based on the criteria relevant to members: for example, the type of medical specialty, the distance from the member's home or office, and whether the provider does telehealth or provides in-person care.

126. The Defendant's directory of mental health providers is a ghost network to a staggering extent. Mental health providers listed on the Defendant's directory have incorrect contact information, or include repeated entries of the same provider, making it appear that Anthem contracts with vastly more mental health providers than it does. Accordingly, the Defendant's provider directory, and representations about Anthem's comprehensive mental health coverage, are inaccurate, deceptive, and misleading.

127. The Defendant's provider directory affirmatively misrepresents to current and prospective Anthem members that the mental health providers listed are in fact in-network and will be accessible and available for mental health services. Indeed, as described above, the

[65] *Benefit Summary Book*, *supra* note 59 at 1.

[66] *Id.* at 10.

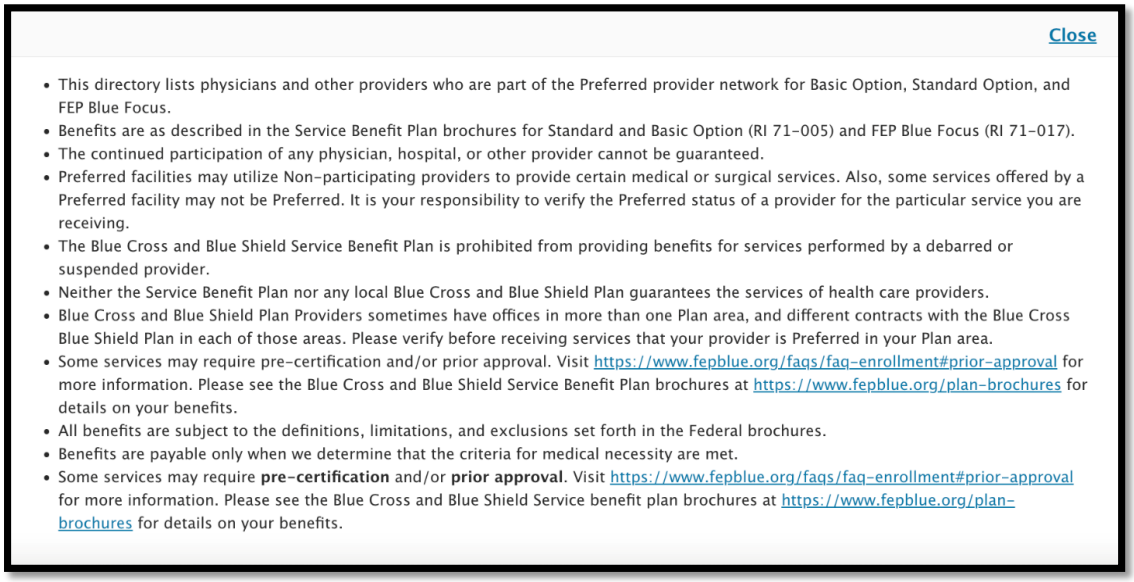
[67] *See Find a Doctor*, *supra* note 61.

Defendant's provider directory is replete with providers who do not take Anthem and is egregiously inaccurate as to its network of mental health providers.

128. The Defendant includes many incorrect or non-working telephone numbers in its directory. The Defendant's inclusion of multiple incorrect telephone numbers may, at first glance, appear to be no big deal. But such errors are far from trivial for a person needing mental health care for themselves or a loved one. The appearance of a phone number next to a provider's name conveys the promise that this provider is not only in-network, but available to the member – to make an appointment and get help. And the absence of a phone number would convey a very different message: that this provider should not be listed. The inclusion of incorrect telephone numbers artificially inflates the perceived size and adequacy of the Defendant's network. And the inclusion of those incorrect numbers has a detrimental impact on members who invest time and energy trying to find a mental health provider – only to be repeatedly led down a blind path.

129. Anthem's directory can also be downloaded as a customized PDF. On the cover sheet of the customized search directory, Anthem states, "This directory is based upon information available at the time of creation. Providers may change their participation status at any time. For the most up-to-date information on provider availability, please access http://FEPBLUE.org."

130. On the search results page, there is a link: "Click here for general Federal Employee Program provider directory disclaimers[,]" which leads to the following pop-up window:



Close

- This directory lists physicians and other providers who are part of the Preferred provider network for Basic Option, Standard Option, and FEP Blue Focus.
- Benefits are as described in the Service Benefit Plan brochures for Standard and Basic Option (RI 71-005) and FEP Blue Focus (RI 71-017).
- The continued participation of any physician, hospital, or other provider cannot be guaranteed.
- Preferred facilities may utilize Non-participating providers to provide certain medical or surgical services. Also, some services offered by a Preferred facility may not be Preferred. It is your responsibility to verify the Preferred status of a provider for the particular service you are receiving.
- The Blue Cross and Blue Shield Service Benefit Plan is prohibited from providing benefits for services performed by a debarred or suspended provider.
- Neither the Service Benefit Plan nor any local Blue Cross and Blue Shield Plan guarantees the services of health care providers.
- Blue Cross and Blue Shield Plan Providers sometimes have offices in more than one Plan area, and different contracts with the Blue Cross Blue Shield Plan in each of those areas. Please verify before receiving services that your provider is Preferred in your Plan area.
- Some services may require pre-certification and/or prior approval. Visit https://www.fepblue.org/faqs/faq-enrollment#prior-approval for more information. Please see the Blue Cross and Blue Shield Service Benefit Plan brochures at https://www.fepblue.org/plan-brochures for details on your benefits.
- All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochures.
- Benefits are payable only when we determine that the criteria for medical necessity are met.
- Some services may require **pre-certification** and/or **prior approval**. Visit https://www.fepblue.org/faqs/faq-enrollment#prior-approval for more information. Please see the Blue Cross and Blue Shield Service benefit plan brochures at https://www.fepblue.org/plan-brochures for details on your benefits.

131. The Defendant's disclaimer statement (above) fails to satisfy the Defendant's obligations to lawfully maintain the provider directory and to refrain from deceptive acts and practices regarding the same.

B. Plaintiffs' "Secret Shopper" Study

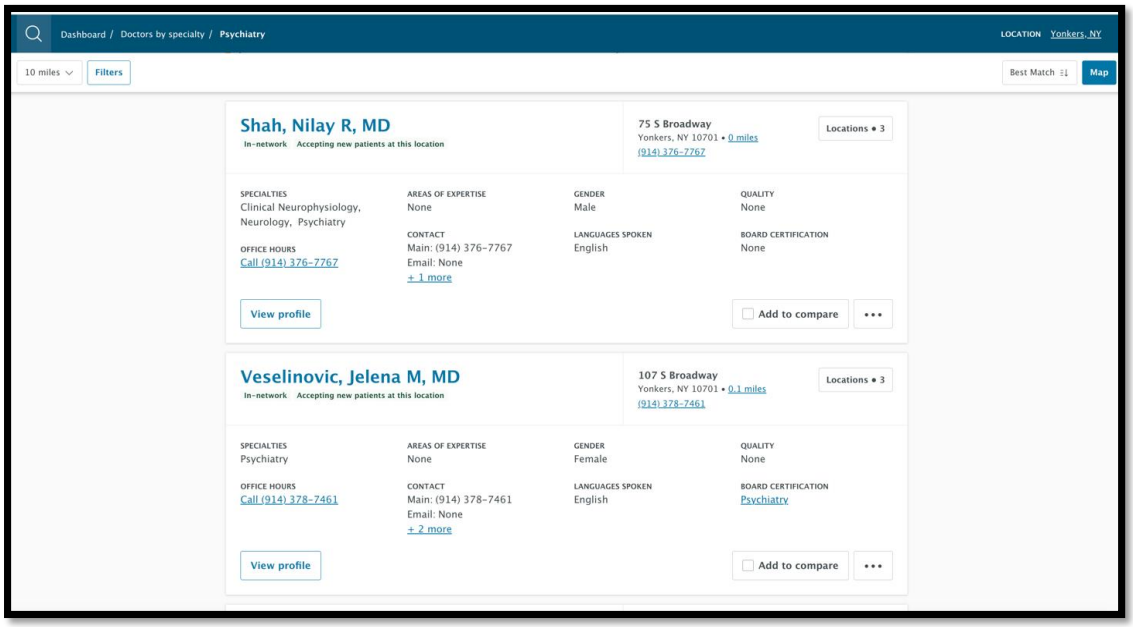
132. In March 2024, counsel for the Plaintiffs conducted a simulated patient "secret shopper" survey very similar in design to those conducted by the New York Office of the Attorney General and Senate Finance Committee.

133. Plaintiffs' secret shopper survey was based upon http://FEPBLUE.org.

134. Plaintiffs' downloaded (and customized) directory was created on March 25, 2024. The bottom of the cover page of that downloaded PDF states, "Data last updated 03/24/2024." Anthem's "Find a Doctor" online tool has a subheading that states, "You can search our nationwide directories of Preferred providers – those providers who are in our network."

135. The "Find a Doctor" tool then asks the member (or prospective member) to choose a location and a specialty. When "Yonkers, New York," "psychiatry," and "10 miles" were put

into the tool, there were 759 results generated. After each doctor's name, it said, "In-network. Accepting new patients at this location."



136. These results were fundamentally wrong and misleading.

137. When searching the online provider directory, Anthem offers the option to "download" the search results at the bottom of the page. Instead of downloading the exact results, which is suggested by the pop-up limiting the number of downloadable results to 200, the downloadable results are completely different. When Counsel downloaded an Anthem directory of psychiatrists within 10 miles of Yonkers, some 4,300 names were generated. But many of those names appeared dozens of times – understandably with different addresses and telephone numbers. But Plaintiffs experienced that several doctors listed multiple times were not in network. Providing a member who is in need of mental health services with a directory that is so inaccurate is little more than an invitation for the member to dive into Alice's rabbit hole.

138. Counsel's staff attempted to contact the first 100 provider listings from a search of Anthem Blue Cross Blue Shield's online provider directory within 10 miles of Yonkers, New York.

139. Plaintiff Cavallaro-Kearins is a resident of Yonkers, and this study was an attempt to replicate a similar experience to when she tried to use the Anthem directory.

140. Using the default sort and phone numbers listed on the provider directory, staff called the first 100 listings trying to secure a mental health appointment (in-person or telemedicine).

141. In total, staff were able to speak with someone for 92 of the listings. Eight listings were completely unreachable due to non-working numbers or unreturned calls.

142. Counsel's staff could only make an in-network appointment with seven of the providers. The rest of the listings were either not in network, not mental health providers, did not accept new patients, were not reachable, or could not get an appointment in less than six months.

143. But even among the seven providers where an appointment could be made, members like the Plaintiff would encounter significant obstacles to getting care. Only two of the seven providers could see a patient for both medication and therapy services in a timely manner. One provider could only provide therapy services and one only offered medication management, and three providers said they had available appointments, but they were a month away from the date of the call.

144. In a vast majority of the attempted calls, the provider was either unreachable, the listed number was incorrect, the provider was not accepting new patients, not in-network, inpatient only, or the provider had another specialty.

145. Twenty-eight of the phone numbers listed were wrong numbers, out of service, or the person listed in the Anthem directory did not work there. Another 27 of the listings were not in-network with Anthem, did not accept Anthem, or were not accepting new patients. Another five of the doctors listed in the Anthem directory were not psychiatrists, psychologists, or therapists.

146. An additional 23 listings were in-patient only.

147. In short, current members of the Anthem plan would encounter severe obstacles in securing in-network care, just as Plaintiffs did.

148. As a result, and as corroborated by named Plaintiffs' experiences, it is nearly impossible to find an available in-network mental health provider on the Defendant's provider directory.

149. In summary, the Defendant's provider directory includes scores of providers who are not in-network with Anthem or do not accept Anthem insurance. Moreover, the Defendant's provider directory is replete with inaccuracies of all kinds, including but not limited to incorrect addresses, phone numbers, and other contact information. Finally, when a member prints out (or saves as a PDF) a directory, the search results generated for a mental health provider include multiple entries for the same provider, making it appear that Anthem has vastly more mental health providers than it does – and potentially sending a member on an even more frustrating search for an in-network provider.

C. Anthem's Marketing Materials and Plan Summaries

150. In addition to publishing and maintaining an inaccurate provider directory, Anthem provides consumers with deceptive and materially misleading marketing and program materials about the Anthem plans. These materials promise mental health benefits and a robust network of in-network providers.

151. During every year's open enrollment period, federal employees select their desired health plan. Last year's open enrollment period was from Monday, November 13 through Monday, December 11, 2023, with the plan year beginning on January 1, 2024. Once an employee selects a health plan, the employee must remain with that plan for the entire plan year (unless there is a "qualifying event" like getting married or losing a job) until the following year's open enrollment period.

152. There are several materials that summarize, and market, the Anthem plan to federal employees during open enrollment, and at all other times during the plan year. These documents, including Anthem's "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan," and the "Find a Doctor" online resource, are made directly available to both current and prospective members or are otherwise available on the Anthem website. Separately and collectively, these documents deceptively describe an insurance plan that provides comprehensive mental health care coverage, and that members and potential members rely upon and assume to be accurate.

153. The "Benefits at a Glance" includes mental health visits.

154. The "Benefit Summary Book" also spells out a benefit of "mental health visits." The "Service Benefit Plan" (brochure) devotes approximately three pages to mental health benefits.

155. In addition, the benefits conveyed to Plaintiffs are found in the document known as the Brochure that is available at www.fepblue.org. The Brochure states: "Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based

on the results of this analysis, we may suggest changes to program benefits to OPM."[68] The Mental Health Parity and Addiction Equity Act states, "The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy." [69]

156. In reality, it is nearly impossible to obtain in-network mental health care, and consumers who relied on Anthem's misrepresentations are left to suffer the consequences of untreated mental illness, incur significant costs to afford out-of-network treatment, and pay premiums for benefits that are illusory.

157. In conclusion, separately and together, Anthem's representations mislead consumers to believe that their mental health needs would be taken care of, that their in-network coverage is comprehensive, and that they only need to look to and rely on the provider network to find necessary mental health care.

158. Moreover, Anthem's repeated focus on the importance of using an in-network provider, and repeated direction of members to use the provider directory to find an in-network provider, belies the materiality of the provider directory to consumers.

159. Finally, Defendant's attempts to have members themselves verify that a provider is in fact in-network does not replace, or otherwise absolve, Defendant's obligations to accurately represent the mental health providers in its network.

---

[68] Brochure, *supra* note 60 at 100.

[69] Ctrs. for Medicare & Medicaid Services, The Mental Health Parity and Addiction Equity Act (2023), https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.

D. Defendant's Omissions

160. In addition to the affirmative misrepresentations made by the Defendant about the breadth of its provider network and comprehensiveness of Anthem's mental health care coverage, the Defendant also makes material omissions, including but not limited to failing to disclose the extent of provider directory inaccuracies; that the vast majority of in-network mental health providers are not accessible; and the limitations of Anthem's mental health coverage.

161. Specifically, the Defendant – on the provider directory and in Anthem's marketing and plan materials – misleadingly omits any mention that members will likely face significant difficulty in finding an in-network mental health provider through the directory, or the likelihood that members will need to either resort to an out-of-network provider or delay or potentially forego care altogether.

162. Significantly, there is also complete information asymmetry between the Defendant and consumers: the Defendant has every ability to access all the relevant information to determine whether a provider is accurately listed.[70] On the other hand, only after great difficulty and time expenditure – through trial and error, hours of calls, and extensive research – could a member become aware of the extent of the directory inaccuracies. The information is simply not readily available to the average consumer.

163. Plaintiffs and other reasonable consumers must rely on the Defendant to accurately represent which providers are in-network for its insurance plan. The Defendant is well-aware of its directory inaccuracies, yet reasonable consumers would have no reason to think that the list of providers represented as being in their insurance plan's network would not be exactly that.

[70] This information includes their contracts and communications with providers, as well as billing information from which Defendant could easily ascertain the providers currently in their network.

164. If Plaintiffs – or any reasonable consumer – had the directory inaccuracies and deficits of Anthem's mental health care coverage disclosed to them, they would have acted differently in a variety of ways, including, but not limited to, avoiding hours of fruitless searches and calls, saving and budgeting to prepare for out-of-network mental health care costs, and exploring other health plan options.

IV. Defendant's Misrepresentations and Omissions about Its Mental Health Care Coverage Are Deceptive

165. The staggering inaccuracies in the Defendant's provider directory, and in Anthem's marketing and plan materials, constitute unlawful deceptive acts and practices, false advertising, and violations of statutory and regulatory requirements. Moreover, these violations are knowing, willful, and serve to unjustly enrich Defendant.

166. The misconduct alleged in this complaint is simple but enormously harmful: the Defendant deceptively and misleadingly represents that the Anthem insurance plan has a broad network of available mental health providers, when the reality is that members often cannot obtain in-network mental health treatment.

167. The Defendant holds itself out to consumers – through the provider directory, advertising and marketing materials, and plan materials – as adequately covering mental health care. These representations are deceptive, as Anthem does not provide an adequate or a comprehensive network of mental health providers.

168. As discussed above, the Defendant affirmatively misrepresents the breadth of its mental health provider network to a staggering extent – with at least 85% of the providers listed on the provider directory not actually participating in Anthem's insurance network. Further, an overwhelming number of providers listed are improperly and repeatedly listed or have incorrect contact information.

169. In addition, during its enrollment periods and otherwise, Anthem makes numerous material misrepresentations to current and potential members about the Anthem plan, including, but not limited to, the size and adequacy of the mental health provider network, that all providers on the directory would be covered at an in-network rate, the ease and availability of finding in-network care, and the comprehensiveness of mental health care coverage. It is also very difficult for members or prospective members to ascertain the "allowance" that Anthem uses to determine out-of-network reimbursement.

170. The Defendant disseminates these uniform, deceptive misrepresentations and omissions on its provider directory and through Anthem's advertising, marketing, and program materials, such as Anthem's "Benefits at a Glance,"[71] the "Benefit Summary Book,"[72] the "Service Benefit Plan"[73] (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource.[74]

171. At no time did the Defendant disclose the limited nature of the mental health provider network, the amount of time individuals could be expected to search for an available in-network mental health provider, or the expenditures that would likely be required to obtain mental health care.

172. Put another way, if a member was looking to obtain mental health services from a provider on the Defendant's provider directory, the member would have no reason to believe that

[71] *Benefits at a Glance*, *supra* note 58.

[72] *Benefits Summary Book*, *supra* note 59.

[73] *Brochure*, *supra* note 60.

[74] *Find a Doctor*, *supra* note 61.

said provider would be out-of-network, nor that the member would have to pay substantial costs to see an out-of-network provider.

173. Through the Defendant's representations, omissions, and bait-and-switch tactics, a reasonable consumer would understandably believe that the Anthem plan included the mental health providers that the provider directory stated it would, and that Anthem's network of mental health providers was broad and accessible. A reasonable consumer would also expect that Anthem would cover charges for services at an in-network rate for the providers it affirmatively lists as in-network on its directory, and that the consumer would not be subject to out-of-network costs for obtaining mental health care from a provider listed on the directory.

174. The Defendant represents that it regularly monitors and updates its network for accuracy. But that is not true.

175. Indeed, the Defendant is flagrantly violating federal law, including the No Surprises Act.

176. Moreover, the Defendant is well-aware of its legal obligations, and the Defendant's inaccurate and misleading provider directory is not only a violation of these standards, but also a willful and knowing violation of the consumer protection laws.

177. The Defendant willfully and knowingly maintains an inaccurate and inflated provider directory to hide its non-compliance with network adequacy standards. If the Defendant were forced to produce an accurate provider directory, it would reflect that Anthem does not maintain sufficient in-network mental health providers, in violation of network adequacy laws.

A. Defendant's Deceptive Representations and Omissions Are Material

178. As countless studies have shown, provider directories and the breadth of a provider network are important to consumers' choice of health care plan and decisions about their health care. By inference, misrepresentations about a provider directory and network materially impact

consumers' health plan choices. Accordingly, the Defendant's misrepresentations about the Anthem plan's mental health provider network and coverage are materially misleading to consumers, in violation of consumer protection law.

179. Consumers predominantly, and logically, rely on a health plan's provider directory in order to find providers in their health plan.[75] As stated by the American Medical Association and the Council for Affordable Quality Healthcare:

> Health plans are expected by their members and their contracted practices to display a provider directory to the public that represents an accurate reflection of their networks. It is the most public-facing data that health plans provide, and patients are dependent on accurate directories to access care….[76]

180. Indeed, and as noted above, Anthem itself repeatedly directs its members to rely on the provider directory to find an in-network provider.

181. In addition, reasonable consumers look to the breadth of a provider network in choosing a health plan.[77] Over half of consumers in one poll identified provider choice as the most important non-financial consideration they make when selecting a health plan.[78] In another

[75] *Improving Health Plan Provider Directories*, CAQH & Am. Med. Ass'n., 3, https://www.caqh.org/sites/default/files/other/CAQH-AMA_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf ("Among the more common resources that patients use are health plan provider directories which, according to two surveys conducted in 2020, more than half of patients use to select a physician.") (citations omitted).

[76] *Id.* at 7.

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

[78] *See* Linda J. Blumberg et al., *Factors Influencing Health Plan Choice among the Marketplace Target Population on the Eve of the Health Reform*, Urban Inst. (Feb. 6, 2014), https://www.urban.org/research/publication/factors-influencing-health-plan-choice-among-marketplace-target-population-eve-health-reform.

survey, participants "were willing to pay $72 more for a plan that covered 30% more doctors in their area."[79] And, in a Kaiser Family Foundation survey, 60 percent of non-group health insurance enrollees reported that having a choice of providers was either "very important" or "extremely important" to them.[80] Anthem is aware of such consumer preferences.

182. Given the materiality of provider directories and network breadth to consumer choice, the misrepresentations and omissions made by the Defendant constitute precisely the type of information upon which reasonable consumers would rely on in choosing a health plan. Having access to an adequate number of in-network, qualified doctors is one of the fundamental criteria consumers use in choosing a health insurance plan.[81]

183. Moreover, and as discussed above, reasonable consumers would understandably rely on these misrepresentations and omissions made by the Defendant. The provider directory and network information are disseminated by the insurance company, which consumers logically view as the authoritative source of information about its in-network providers, scope of coverage, and other plan policies.

184. Any disclaimers, such as "the continued participation of any physician, hospital, or other provider cannot be guaranteed," are woefully insufficient.

---

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

[80] Liz Hamel et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2*, Kaiser Family Foundation (2015), https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/ (note that 60 percent is the combined statistic of those who reported choice of providers as "extremely important" (25 percent) or "very important" (38 percent)).

[81] *See id.*; *Most Important Considerations for Americans in Choosing a Plan from a Health Insurance Company as of 2016*, *supra* note 77; Blumberg et al., *supra* note 78; van den Broek-Altenburg, *supra* note 79.

185. The Defendant's attempt to have members themselves verify that a provider listed on its directory of in-network providers is in fact in-network is cynical, inappropriate, and dangerous. The Defendant cannot shift its obligations to consumers in an effort to evade its legal duties. It is not consumers' responsibility to verify if they are being misled; instead, it is the Defendant's obligation not to mislead.

186. The sheer extent of inaccuracy and inadequacy of the Defendant's network is hidden, dangerous and deceptive. Put another way, no reasonable consumer viewing these disclaimers would understand that up to 85% of mental health providers listed on the directory do not take Anthem insurance. Indeed, there is no disclaimer broad enough to absolve that level of deception.

B. Defendant Was Aware of Its Provider Directory Inaccuracy and Knew That Its Representations and Omissions Regarding the Provider Directory and Mental Health Care Coverage Were Deceptive

187. At all relevant times, the Defendant knew that its representations and omissions regarding its directory of mental health providers and coverage of mental health care were grossly inaccurate, deceptive, and misleading.

188. Amongst the insurance industry itself (as opposed to consumers), it is well known that provider directories are notoriously inaccurate. There are numerous studies documenting the

prevalence of ghost networks,[82] especially for mental health providers,[83] and insurance companies – including Anthem – have been successfully sued over the issue.[84]

189. As discussed above, the industry was recently the subject of a bipartisan congressional inquiry into ghost networks,[85] and the Senate Finance Committee held a hearing on the issue specifically in the context of mental health.[86] There are also numerous federal and state laws and regulations aimed at rectifying the problem of inaccurate provider directories, which are discussed further below, and of which the Defendant is well aware.

---

[82] *See, e.g.*, Butala et al., *supra* note 28 ("In examining directory entries for more than 40% of US physicians, inconsistencies were found in 81% of entries across 5 large national health insurers."); Jack S. Resneck Jr. et al., *The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks*, JAMA Dermatology 150(12) (2014), https://jamanetwork.com/journals/jamadermatology/fullarticle/1919439 (finding, after making scripted telephone calls to dermatologists listed in certain directories, that 45.5% of physician listings were duplicates, and many "dermatologists listed had incorrect contact information, were deceased, retired, or had moved, were not accepting new patients, did not accept the insurance plan, or were subspecialized;" for one plan, no appointment was obtainable).

[83] *See, e.g.*, Russell Holstein & David P. Paul III, *'Phantom Networks' of Managed Behavioral Health Providers: an Empirical Study of their Existence and Effect on Patients in Two New Jersey Counties*, Hospital Topics 90(3), 68 (2012), https://pubmed.ncbi.nlm.nih.gov/22989224/ ("Aetna's network of psychologists was the most accurate of all networks, and GHI's network of psychiatrists was the most inaccurate of all networks."); Jane M. 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 ("Overall, 58.2 percent of network directory listings were "phantom" providers who did not see Medicaid patients, including 67.4 percent of mental health prescribers, 59.0 percent of mental health nonprescribers, and 54.0 percent of primary care providers.").

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

[85] *See* Press Release, *Brown, Colleagues, Seek Information on Ghost Networks*, Sherrod Brown U.S. Senator for Ohio (Jan. 30, 2023), https://www.brown.senate.gov/newsroom/press/release/sherrod-brown-colleagues-seek-information-on-ghost-networks.

[86] *See* Senate Hearings on Mental Health Care, *supra* note 35.

190. Put simply by a state senator, "[Insurance companies] have known about this for a long time and they haven't done anything about it. It's difficult not to assume that this kind of barrier is intentional."[87]

191. The sheer magnitude of providers who are not in-network or do not accept an Anthem plan – at least 85% of the mental health providers listed – in and of itself reflects knowledge of the directory inaccuracies. The staggering extent of inaccuracy of the mental health providers represented as being in-network can only be the product of knowing misconduct or willful blindness.

192. The federal government regularly surveys employees about their use and satisfaction of various benefits, including the Federal Employees Health Benefits (FEHB) Program.

193. In June 2022, the United States Office of Personnel Management published its 2021 Federal Employee Benefits Survey Report. This survey was administered to more than 50,000 permanent employees across the federal government.[88]

194. The objective and findings were absolutely relevant to this lawsuit:

> To gauge the overall need for mental/behavioral healthcare in the Federal workforce, participants were first asked whether there was a need for care for themselves or for a family member within the 12 months prior to completing the survey. The results were consistent with 2019 FEBS results- 28 percent of participants responded "yes", 66 percent responded "no", and six percent responded "no, but there was a need for treatment."

[87] Turban, *supra* note 57.

[88] U.S. Office of Personnel Mgmt., *2021 Federal Employee Benefits Survey Report*, https://www.opm.gov/policy-data-oversight/data-analysis-documentation/employee-surveys/2021-federal-employee-benefits-survey-report.pdf.

195. Survey participants were equally clear about their difficulty accessing mental health care. As the survey report explained:

> For the six percent of participants who indicated that treatment was necessary but that it had not been obtained, a follow up question was asked to better understand what barriers Federal employees may be encountering when attempting to seek care.

Barriers Encountered When Attempting to Seek Mental or Behavioral Health Treatment	
Reason for Not Seeking Care	**Percent Selected**
Difficulty finding an in-network provider	33%
Difficulty finding providers accepting new patients	30%
Could not afford treatment costs	23%
Difficulty finding in-person appointments	18%
Difficulty finding virtual appointments	12%

196. The Defendant knew, or should have known, that members were having significant problems accessing in-network care, and that 6% of federal employees surveyed reported that they had abandoned their search for mental health care.

197. For all of these reasons, the Defendant's misrepresentations and omissions constitute knowing and willful violations.

198. The Defendant engaged in these knowing deceptive acts and practices to induce Plaintiffs, and all potential members and consumers, to choose the Anthem plan. These representations about the size and breadth of the mental health provider network, the ease of finding mental health treatment by using the allegedly accurate provider directory, the freedom to choose any listed in-network provider, the ability to control costs by seeing an in-network provider, and the comprehensive coverage of mental health care would induce a reasonable consumer to choose the Anthem plan.

C. Defendant Reaps Significant Benefits from Misrepresenting Its Mental Health Provider Network and Coverage

199. Moreover, the Defendant knowingly and intentionally misleads consumers in order to inflate the perception, extent, and robustness of its supposed mental health provider network, which inures significant financial benefits to the Defendant, and conversely, deprives Anthem members of the benefit of the bargain for the plan that they chose.

200. Maintaining an inaccurate provider network and proving inadequate mental health care coverage significantly boosts the Defendant's profits.

201. As discussed above, the top considerations for consumers choosing a health plan are network breadth and provider choice. In addition to general representations made by insurers about their networks, the main source upon which consumers rely to determine a network's breadth is the provider directory.[89]

202. Consumers are more likely to enroll in a particular plan if their provider is in-network and the provider list is robust. Thus, by misrepresenting the size and quality of its network, the Defendant attracts more customers.

203. When a provider network appears to be extensive, it attracts many potential members and increases its share of the market; and indeed, Anthem's plan maintains a significant market share of FEHP-eligible consumers.

204. These members' premiums are then paid to Anthem. As such, Anthem is unjustly enriched from its misrepresentations about the breadth of its network.

---

[89] *See Improving Health Plan Provider Directories*, CAQH & Am. Med. Ass'n., 3, https://www.caqh.org/sites/default/files/other/CAQH-AMA_Improving%20Health%20Plan%20Provider%20Directories%20Whitepaper.pdf ("Among the more common resources that patients use are health plan provider directories which, according to two surveys conducted in 2020, more than half of patients use to select a physician.") (citations omitted).

205. Anthem also overcharges for its premiums because of its illusorily broad network. Every provider who is not actually in-network, or who is unavailable or unable to be contacted, represents coverage that Anthem is paid for, but that members never receive.[90]

206. In addition, members with greater mental health care needs are disproportionately harmed by the lack of in-network providers. These higher-needs members are more likely to have to pay for out-of-network treatment or abandon their efforts to obtain mental health care altogether, thereby saving Anthem the costs associated with their care.

207. Simply put, inaccurate directories serve to increase a plan's membership (along with their increased premiums) and, at the same time, evade the costs of covering their care.

208. The financial incentives of intentionally inaccurate directories were discussed during the recent Senate Finance Committee hearing.[91] In an exchange between United States Senator Elizabeth Warren and testifying witness Mary Giliberti (the Chief Public Policy Officer of Mental Health America), Senator Warren inquired whether the plans were "inaccurate by design," to which Ms. Giliberti responded affirmatively:

> SENATOR WARREN: Okay so it's a way to defraud consumers. To say I have this really big list of people you could go to if you had a problem, and it turns out that really big list … is actually this little tiny list.
>
> MS. GILIBERTI: Right.
>
> SENATOR WARREN: Okay so that's one way it's to their advantage … . They get paid in effect or they make more money by being inaccurate. Did you have another one?

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

[91] Note that this discussion focused on Medicare Advantage plans, but the incentives are the same in commercial plans.

> MS. GILIBERTI: Well just that I think it's about 60 percent of the plans [being discussed] don't have out of network coverage so if you get really frustrated and you pay on your own then they're not paying anything.
>
> SENATOR WARREN: So the more I can frustrate you … the more you'll just go somewhere else. And that means it's not money out of their pockets.
>
> * * *
>
> SENATOR WARREN: So what we are really saying here is that it is in the financial interests of these … plans to discourage beneficiaries from accessing care … . Because here's the key that underlines this. Whatever insurers don't spend on care as a result of tactics like outdated provider directories or overly restrictive networks or inaccurate information, whatever they don't spend on care, they get to keep.[92]

209. Finally, a significant collateral consequence of an inaccurate, inflated provider directory is that an insurance plan appears to meet network adequacy requirements, even though it does not. The Defendant is thereby unjustly enriched by avoiding the compliance costs and other expenditures associated with maintaining an accurate and adequate network of mental health providers, as required by federal and state law and discussed further below.

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

> Directory errors cost consumers money and erode regulatory consumer safeguards. They deceive consumers about the value of the coverage they are purchasing by concealing plans' actual provider networks, subjecting consumers to predatory billing practices, and breaking the link between consumer choices and plan practices that undergirds much of the American health insurance regulatory structure.[93]

---

[92] Senate Hearings on Mental Health Care, *supra* note 35 (Testimony of Senator Elizabeth Warren).

[93] Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 Yale L. & Pol'y Rev. 78, 85 (2021).

V. Plaintiffs and Putative Class Members Have Been Injured Because of Defendant's Conduct

211. Simply put, the Defendant's ghost network is a dangerous obstacle to critical mental health care for the hundreds of thousands of people covered by Anthem's plan. Plaintiffs and others similarly situated – both adults and the parents of children in desperate need of mental health care – have been grievously injured by these violations and their inability to access necessary mental health treatment for their children.

212. Mental health care networks have been known for some time for being particularly inaccurate and causing significant harms.[94] Yet insurance companies such as the Defendant have done little to improve their accuracy.

213. As noted in a 2014 New York Attorney General Assurance of Discontinuance, "[p]ersons with mental health and substance use disorders comprise a vulnerable population, and may be reluctant to seek care."

214. Plaintiffs have suffered enormous injury from the Defendant's violations of law. As a result of the Defendant's ghost network, Plaintiffs have struggled, or been wholly unable, to obtain mental health treatment for themselves or their children. Specifically, Plaintiffs have paid exorbitant costs to get mental health treatment because they have been forced to seek out-of-network care for themselves and for their children; have faced significant, years-long delays in receiving critical mental health care; have been unable to find care appropriate for their mental

[94] *See, e.g.*, Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39(6) Health Affairs (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501 ("We conducted a national survey of privately insured patients who received specialty mental health treatment. We found that 44 percent had used a mental health provider directory and that 53 percent of these patients had encountered directory inaccuracies.").

health needs and have made-do with less-than-appropriate providers; and, alarmingly, have been unable to obtain needed mental health treatment altogether.

215. The provider directory's inaccuracies and misrepresentations and omissions about Anthem's mental health care coverage are the direct causes of the harms Plaintiffs have endured. Most simply, had the provider directory been accurate, Plaintiffs would have saved countless hours of futile searching; avoided the time, costs, and emotional toll of delaying, or failing to find, needed care; and avoided the exorbitant costs of obtaining out-of-network mental health treatment. Had Anthem accurately represented its mental health care coverage, Plaintiffs would have had access to the care they were promised or made other financial and health care decisions about their mental health treatment.

CLASS ACTION ALLEGATIONS

216. This action is brought by Plaintiffs individually and on behalf of a class (the "Class") pursuant to Federal Rule of Civil Procedure 23(a) and (b).

217. Plaintiffs seek certification of the following Class:

> All persons who are currently, or were previously, enrolled in Anthem's FEHP plans at any point in or after 2018 who attempted to utilize Anthem's directory of mental health providers.

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

219. Plaintiffs reserve the right to amend or modify the class definition.

220. **Numerosity.** The Class consists of many thousands of federal employees, retired employees under 65, and their dependents that are or have been members of the Anthem FEHP plans and is thus so numerous that joinder of all members is impracticable. The exact number

and identity of class members is unknown to Plaintiffs at this time but can be ascertained through appropriate discovery.

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

a) whether the Defendant breached its contractual obligations by failing to comply with the No Surprises Act and/or other federal statutes, regulations, and rules with which the Defendant is contractually obligated to comply;

b) whether the Defendant's misrepresentations regarding the Anthem FEHP plans in violation of federal law were false or misleading under New York General Business Law ("GBL") §§ 349 and/or 350, New York Insurance Law § 4226(a), and/or common law;

c) whether such violations were willful and knowing;

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

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

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

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

h) whether Plaintiffs and Class members conferred a benefit on Anthem through enrollment in the Anthem plan, payment of premiums, and not utilizing in-network providers or otherwise not obtaining mental health care; and

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

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

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

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

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

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

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

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

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

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

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

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

FIRST CAUSE OF ACTION

Breach of Contract

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

228. Plaintiffs and the Class, as federal employees eligible to participate in the Federal Employee Health Benefits Program, are third-party beneficiaries of a contract between the Federal Office of Personnel Management and the Defendant.

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

230. Sections 2799A-5 of the Public Health Service Act, 720 of the Employee Retirement Income Security Act of 1974, and 9820 of the Internal Revenue Code of 1986 require health insurers to verify and update their provider directory not less frequently than once every 90 days, remove a provider from the directory when it is unable to verify the directory information for that provider, and update the directory within two days of receiving new information from a provider.

231. Defendant's failure to maintain an accurate directory of in-network providers, and other misconduct set forth in this complaint, violates the requirements in the Public Health Service Act, Employee Retirement Income Security Act, and Internal Revenue Code.

232. The Defendant has violated the above federal laws (and, by extension, its contractual obligations to Plaintiffs and the Class) by, among other things, failing to consistently provide an accurate network directory and failing to ensure mental health network adequacy.

233. Plaintiffs and the Class have been harmed by the Defendant's numerous contractual breaches. Among other injuries, the Defendant's contractual breaches have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forego crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; prevented Plaintiffs and Class members from receiving the full benefit of their bargain; prevented Plaintiffs and Class members from enrolling in a plan with better benefits (including lower costs); caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

SECOND CAUSE OF ACTION

Deceptive Acts and Practices in Violation of the New York Deceptive Acts & Practices Act, N.Y. Gen. Bus. Law § 349

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

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

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

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

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

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

240. In the course of business, the Defendant made deceptive affirmative misrepresentations and omissions to Plaintiffs and the Class by publishing and disseminating misleading informational and marketing materials prior to and during the open enrollment periods regarding Anthem—including Anthem's "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource. The provider directory itself, which members and prospective members are directed to rely on, inflates and misleads consumers regarding the size of the network and the availability of mental health providers.

241. False representations include, *inter alia*, that providers listed on the provider directory are in-network; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers; and that mental health care coverage is comprehensive.

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

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

244. These misrepresentations and omissions alleged herein were materially misleading.

245. The acts and practices alleged herein are deceptive acts and practices covered under GBL § 349 and have caused Plaintiffs and Class members significant ascertainable monetary and non-monetary injuries. Among other injuries, the Defendant's deceptive acts and practices have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forego crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; prevented Plaintiffs and Class members from enrolling in a plan with better benefits (including lower costs); caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

246. The Defendant willfully and knowingly violated GBL § 349. It made affirmative misrepresentations and omissions in its marketing materials and provider directory—in violation of federal law—in order to market the Anthem plans as comprehensive, including mental health coverage, in order to induce federal employees to choose its plans over other plans.

THIRD CAUSE OF ACTION

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

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

248. The Defendant violated GBL § 350 by failing to provide Plaintiffs and the Class with the accurate information about in-network providers required by federal law, including, but not limited to, the No Surprises Act, Public Health Service Act, Employee Retirement Income Security Act, and Internal Revenue Code.

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

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

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

252. A cause of action based upon false advertising is appropriate because the Defendant utilized false advertising to mislead Plaintiffs and the Class about the nature and coverage of Anthem, in violation of federal law.

253. In the course of business, the Defendant falsely advertised the Anthem plans to Plaintiffs and the Class by publishing and disseminating misleading informational and marketing materials prior to and during the open enrollment periods including Anthem's "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource. The

provider directory itself, which members and prospective members are directed to rely on, inflates and misleads consumers regarding the availability of mental health providers and the adequate size of the network, in violation of federal law.

254. False representations include that providers listed on the provider directory are in-network; that there are sufficient and available mental health care providers in that network; that members can rely on the directory to find and contact providers; and that the mental health care coverage is comprehensive.

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

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

257. The false advertising alleged herein was materially misleading.

258. The acts and practices alleged herein constitute false advertising covered under GBL § 350 and have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forego crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; prevented Plaintiffs and Class members from enrolling in a plan with better benefits (including lower

costs); caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed financial and health care decisions; and caused Plaintiffs and Class members to suffer severe emotional and psychological distress.

259. The Defendant willfully and knowingly violated GBL § 350. It made affirmative misrepresentations and omissions in its marketing materials and provider directory—in violation of federal law—in order to market the Anthem plans as comprehensive, including mental health coverage, in order to induce federal employees to choose its plans over other plans.

FOURTH CAUSE OF ACTION

Violation of New York Insurance Law § 4226

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

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

262. The Defendant is liable under New York Insurance Law § 4226 because (1) it is authorized to provide health insurance in New York; (2) it misrepresented to Plaintiffs and the Class that they would have comprehensive access to in-network mental health care, including that the mental health providers listed on the provider directory accepted the Anthem insurance plans, that these providers would be accessible and available, and more; (3) the misrepresentations were material; (4) the Defendant knew that it had misrepresented the terms,

benefits, and advantages of the Anthem plans and has long been on notice of its provider directory deficiencies; (5) the Defendant knew that the "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), the "Find a Doctor" online resource, and other documents containing the misrepresentations would be communicated to the Plaintiffs and the Class, directly and indirectly; (6) Plaintiffs and the Class received such documents and learned of the misrepresentations, directly and indirectly; (7) the Defendant did not abide by its representations; and (8) Plaintiffs and the Class were thereby injured.

263. The Defendant issued statements via the provider directory, the "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource, and other documents that materially misrepresented – through affirmative misstatements as well as omissions – the comprehensiveness of the Anthem plans and mental health care coverage.

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

265. Plaintiffs and Class members have suffered economic and non-economic injuries as a result of the Defendant's misconduct. Among other injuries, the Defendant's misconduct has caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forego crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; prevented Plaintiffs and Class members from enrolling in a plan with better benefits (including lower costs); caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class

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

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

FIFTH CAUSE OF ACTION

Fraudulent Misrepresentation

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

268. Insurance companies have a statutory obligation to provide accurate and complete information about their health care plans.

269. The Defendant made deceptive affirmative misrepresentations and omissions to Plaintiffs and the Class by publishing and disseminating misleading informational and marketing materials prior to and during the open enrollment periods. The Defendant's misrepresentations were conveyed in Anthem's "Benefits at a Glance," the "Benefit Summary Book," the "Service Benefit Plan" (also known as the "brochure" and "official statement of benefits"), and the "Find a Doctor" online resource. The provider directory itself, which members and prospective members are directed to rely on, inflates and misleads consumers regarding the size of the network and the availability of mental health providers.

270. The omissions from these same resources were any reference to the limited number of mental health providers who are actually in-network with Anthem and actually accepted the Anthem insurance, or to the fact that members and prospective members have to utilize out-of-network providers – and incur substantial costs – should they need mental health services.

271. False representations include, *inter alia*, that providers listed on the provider directory are in-network; that there are sufficient and available mental health care providers in

that network; that members can rely on the directory to find and contact providers; that Anthem has an adequate size network; and that mental health care coverage is comprehensive.

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

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

274. These misrepresentations and omissions alleged herein were intentional and materially misleading.

275. These misrepresentations and omissions have caused Plaintiffs and Class members significant ascertainable monetary and non-monetary injuries. Among other injuries, the Defendant's misrepresentations and omissions have caused millions of dollars in damages; forced Plaintiffs and Class members to delay and forego crucial and necessary mental health care; caused Plaintiffs and Class members significant out-of-pocket expenses for out-of-network provider payments; prevented Plaintiffs and Class members from enrolling in a plan with better benefits (including lower costs); caused Plaintiffs and Class members to reduce spending on necessities and other life costs; prevented Plaintiffs and Class members from making informed

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

276. The Defendant willfully and knowingly made the false representations and omissions alleged herein. Its inclusion of affirmative misrepresentations and omissions in its marketing materials and provider directory was done intentionally to induce federal employees to choose Anthem over other plans, thus increasing Anthem's profits.

SIXTH CAUSE OF ACTION

Unjust Enrichment

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

278. The Defendant has been and continues to be significantly and unjustly enriched because of its inaccurate and inadequate mental health provider network that violates federal law. Because it portrayed its network as accurate and comprehensive, in compliance with federal law, individuals selected its plans. These deceptive representations attracted increased membership, thereby increasing Anthem's share of the marketplace.

279. Plaintiffs and Class members have conferred a benefit on the Defendant by enrolling in Anthem plans and thereby directing their medical premiums to the Defendant.

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

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

282. In addition, Anthem's inflated mental health provider network makes it appear that Anthem complies with federal requirements that its provider network be accurate and adequate, thereby saving Anthem the costs of actual compliance with these requirements – shielding Anthem from government investigation, and the associated costs, at the expense of its members.

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

284. It is inequitable and unjust for the Defendant to retain the benefits from falsely portraying its provider network in a way that increases enrollment while decreasing the Defendant's obligations to comply with federal law.

DEMAND FOR RELIEF

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

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

b. declaring that the Defendant's actions violate federal law, including the No Surprises Act, Public Health Service Act, Employee Retirement Income Security Act, and Internal Revenue Code;

c. awarding all injunctive relief permitted by law or equity, including injunctive relief

prohibiting the Defendant from continuing to violate federal law;

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

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

f. awarding treble damages;

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

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

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

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

* * *

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a trial by jury.

Dated: October 22, 2024

POLLOCK COHEN LLP

By: /s/ *Steve Cohen*
Steve Cohen
111 Broadway, Suite 1804
New York, NY 10006
(212) 337-5361
Scohen@PollockCohen.com

WALDEN MACHT HARAN & WILLIAMS LLP

By: /s/ *Jacob Gardener*
Jacob Gardener
250 Vesey St., 27th Floor
New York, NY 10281
(212) 335-2965
jgardener@wmhwlaw.com

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JANE DOE on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated, Plaintiffs, v. ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS, Defendant.	Civil Action No. 1:24-cv-08012

DECLARATION OF BRENDAN G. STUHAN IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

Pursuant to 28 U.S.C. § 1746, Brendan G. Stuhan, under penalty of perjury under the laws of the United States of America, declares the following to be true and correct:

1. I am over twenty-one years of age, of sound mind, and fully competent to make this declaration. Based on my personal knowledge and experience at the Blue Cross and Blue Shield Association ("BCBSA") and on my review of documents related to the substance of this Declaration as indicated below, the matters below are true and correct.

2. I have personal knowledge of the matters stated in this Declaration and could and would competently testify to them if called as a witness.

3. I am employed as Deputy General Counsel by BCBSA in Washington, D.C. In that role, I am involved and familiar with the Blue Cross and Blue Shield Service Benefit Plan, which is one of the federal government's health benefits plans for federal employees, annuitants, and

their dependents and which is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA"). "Federal Employee Program" (or "FEP") is a nickname for the Blue Cross and Blue Shield Service Benefit Plan.

4. The Service Benefit Plan is formed by a federal government contract – Contract No. CS 1039 – between the United States Office of Personnel Management ("OPM") and BCBSA. BCBSA is the carrier of the Service Benefit Plan. BCBSA enters into that contract on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies. Local Blue Cross and/or Blue Shield companies are independent licensees of BCBSA. Defendant Anthem HealthChoice Assurance, Inc. ("Anthem") is such a company and administers the Service Benefit Plan in parts of New York state.

5. OPM and BCBSA (on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies such as Anthem) have entered into Contract No. CS 1039 annually for decades. Periodically, the entire contract is restated in what I will refer to as the "OPM-BCBSA Contract." The most recent OPM-BCBSA Contract is the 2025 version, and the 2022 version and 2013 version are the most recent versions before that. With minor redactions in Appendix B thereto, true and correct copies of the 2013 and 2022 OPM-BCBSA Contract are attached hereto as Exhibits A and B, respectively.

6. In other years, OPM and BCBSA (on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies such as Anthem) have entered into annual amendments to the most recent version of the OPM-BCBSA Contract. With minor redactions in Appendix B thereto, true and correct copies of the 2018, 2019, 2020, and 2021 annual amendment to the 2013 OPM-BCBSA Contract are attached hereto as Exhibits C, D, E, and F, respectively. With minor redactions in Appendix B thereto, true and correct copies of the 2023 and 2024 annual amendments

to the 2022 OPM-BCBSA Contract are attached hereto as Exhibits G and H, respectively.

7. Each year, the Service Benefit Plan's Statement of Benefits is incorporated into the applicable OPM-BCBSA Contract or annual contract amendment. True and correct copies of the 2018 through 2024 Statement of Benefits for the Service Benefit Plan are attached hereto as Exhibits I, J, K, L, M, N, and O, respectively. Each annual Statement of Benefits is also available for download on OPM's official government website. For example, the 2024 version can be downloaded at: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/pdf/2024/brochures/71-005.pdf (last visited March 25, 2025). Other versions can be downloaded by changing the year in that web address.

Executed on this the 25th day of March 2025.

BRENDAN G. STUHAN

EXHIBIT B

FEDERAL EMPLOYEES

HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2022

CONTRACT FOR FEDERAL EMPLOYEES' HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 2022

AMENDMENT NO: 2022A
EFFECTIVE: January 1, 2022

BETWEEN: The United States Office of Personnel Management
hereinafter called OPM or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G Street, NW
Washington, DC 20005

In consideration of payment by OPM of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
William A. Breskin	Sylvia V. Pulley
Name of person authorized to execute contract (*type or print*)	Name of Contracting Officer (*type or print*)
Title: Senior Vice President Government Program	Title: Contracting Officer
Signature: William A. Breskin	Signature: Sylvia V. Pulley
Date signed: December 21, 2021	Date signed: December 30, 2021

PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 2012)

For purpose of this contract, the following definitions apply:

Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.

Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

Enrollee: The Federal employee, Tribal Employee, annuitant, former spouse, temporarily-covered former Federal employee or family member enrolled under this contract.

FEHBP: Federal Employees Health Benefits Program.

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "Carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

Member: The Enrollee and/or an eligible family member for benefit purposes, and sometimes referred to as subscriber.

Regulations: (1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) Chapters 1 and 16 of title 48, Code of Federal Regulations.

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

Tribal Employee: A full-time or part-time common law employee of a tribal employer.

Tribal Employer: A Tribal Employer is an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. Chapter 18, carrying out at least one program under the Indian Self-Determination and Education Assistance Act or an urban Indian organization as that term is defined in 25 U.S.C. Chapter 18 carrying out at least one program under the title V of the Indian Health Care Improvement Act, provided that OPM accepts the tribe, tribal organization, or urban Indian organization's agreement to offer FEHB.

SECTION 1.2
ENTIRE CONTRACT (JAN 2009)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. Requests for modifications of this contract must be submitted to the authorized Contracting Officer. Only the Contracting Officer acting within the scope of his or her authority may execute a contract modification on behalf of the government.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890 of title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 -- Changes--Negotiated Benefits Contracts.

SECTION 1.5
RECORDS AND INFORMATION TO BE FURNISHED BY OPM (JAN 2012)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, Tribal Employer, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The Carrier is entitled to rely on information furnished to it under paragraph (a). OPM agrees that any liabilities incurred under this contract in reliance upon such information shall be a valid charge against the contract. Errors or delays in keeping or reporting data relating to coverage shall not invalidate coverage that would otherwise be validly in force and shall not continue coverage that would otherwise be terminated. OPM shall make an equitable adjustment of premiums upon discovery of errors or delays under this Section.

(c) Clerical error (whether by OPM, any other agency, Tribal Employer, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. OPM shall make an equitable adjustment of premiums when an error, delay, or failure is discovered. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract and in what amount or to what extent. Any claim payments the Carrier makes before an adjustment or determination shall be a valid charge against this contract.

(d) The OPM shall direct the agencies and Tribal Employers to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government, the Tribal Employer, or the FEHB Clearinghouse.

(e) In instances of erroneous enrollments where benefit payments have been made in error, the Carrier must inform Enrollees within forty-five days of when the Carrier receives notification from the agency or the Tribal Employer that the Carrier will collect for these benefit payments. The Carrier shall provide notice to the Enrollees that they have the right to contest their enrollment change with their agency, Tribal Employer, or their retirement system.

SECTION 1.6
CONFIDENTIALITY OF RECORDS
(JAN 1991) (FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a

statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 2022)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish to OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist (Contracts) immediately upon a change in the name or address of the Carrier's contracting official(s).

(e) If a third party requests FEHB Program data, including FEHB members' medical records and information relating thereto, and the Carrier determines that the data request is not reasonably necessary for administration or performance of the FEHB contract, the Carrier shall determine whether it intends to release the data. If the Carrier intends to release the data, it must notify the OPM Health Insurance Specialist within three (3) business days from the date the Carrier makes the determination. The Carrier must not distribute the data unless it receives prior approval from the Contracting Officer. If the Carrier determines the data is reasonably necessary for administration or performance of the FEHB contract, the Carrier must be able to support that determination. Examples include, but are not limited to:

Example 1: A PBM requests data from the Carrier about the FEHB group's utilization relevant to the PBM's performance of its contract. The release of relevant utilization data is reasonably necessary.

Example 2: A PBM requests data from the Carrier about the FEHB group's utilization for its own marketing purposes. This release is not reasonably necessary.

Example 3: A PBM marketing consultant requests data from the Carrier about the FEHB group's utilization demographics for its own business marketing purposes. This release is not reasonably necessary.

Example 4: A state All Payer Claims Database requests the FEHB group's claims information pursuant to state law. The state uses this data to inform its state insurance regulatory policy. This release is not reasonably necessary.

Example 5: A Federal agency seeks the FEHB group's cost information to inform its benefits policy. This release is not reasonably necessary.

SECTION 1.8
NOTICE (JAN 2003)

Where the contract requires that notice be given to the other party, such notice must be given in writing to the address shown on this contract's signature page. To notify OPM, the Carrier must write to the Contracting Officer, unless otherwise specified.

SECTION 1.9
PLAN PERFORMANCE--EXPERIENCE-RATED FFS CONTRACTS (JAN 2021)

(a) Detection of Fraud, Waste, and Abuse (FWA). The Carrier shall conduct a program to assess its vulnerability to FWA to include but not limited to performing post-payment reviews and audits of providers identified either proactively or reactively. The Carrier shall operate a system designed to detect and eliminate FWA internally by Carrier employees and Subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issues impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA program. The Carrier must submit annual reports to OPM by March 31 addressing the following:

1) Number of Allegations/Complaints Opened/Received;
2) Number of Allegations/Complaints where there is FEHBP Program Exposure;
3) Number of Cases Developed Through Proactive Fraud Prevention/Detection Software;
4) Number of Cases Referred to Local, State, or Federal Law Enforcement/Oversight Agencies;
5) Number of Case Notifications/Referrals Sent to OPM-OIG;
6) Number of Cases Resolved Administratively;
7) Dollars Identified as Loss;
8) Estimated Financial Losses;
9) Non-Recoverable Loss;
10) Dollars Recovered by SIU;
11) Vendor Recoveries;
12) Actual Savings;
13) Prevented Loss;
14) Number of Criminal Convictions;
15) Prepayment Review;
16) Fraudulent Schemes;
17) Fraudulent Geographic Areas;
18) FWA Program Costs;
19) Other Associated Costs of the FWA Program;
20) Return on Investment; and
21) Best Practices

The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the

health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its Members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM contract representative.

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) 5.0 Survey to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the required standards provided in this section. No later than July 1 of the subsequent year, the Carrier shall submit to OPM an annual report of metrics on each specification provided in this section, using data for the contract period:

(1) *Claims Processing Accuracy*

SPECIFICATION: the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.

REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.

(2) *Claims Coding Accuracy*

SPECIFICATION: the number of FEHB claims coded accurately divided by the total number of FEHB claims coded.

REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.

(3) *Recovery of Erroneous Payments*

SPECIFICATION: the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Claims Timeliness*

SPECIFICATION: the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.

REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.

(5) *Processing ID cards on change of plan or option*

SPECIFICATION: the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.

(6) *Member Inquiries*

SPECIFICATION: the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.

REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.

(7) *Written Inquiries Accuracy*

SPECIFICATION: the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.

REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.

(8) *Telephone Inquiries Accuracy*

SPECIFICATION: the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) *Internet Inquiries Accuracy*

SPECIFICATION: the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.

(10) *Telephone Access*

SPECIFICATION: the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness

SPECIFICATION: the percentage of calls answered by a live voice (during operating hours) within 30 seconds.

REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) Telephone Blockage Rate

SPECIFICATION: the number of calls receiving a busy signal when calling the Carrier divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) Telephone Abandonment Rate

SPECIFICATION: the number of calls attempted but not connected to a live voice divided by the total number of calls attempted.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(*iv*) *Initial Call Resolution*

SPECIFICATION: the number of initial calls that result in a resolution of the issue divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.

(11) *Responsiveness to FEHB Member Requests for Reconsideration*

SPECIFICATION: the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim divided by the total number of requests for reconsideration of disputed claims received.

REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) FEHB Clearinghouse (CLER). The Carrier shall not have any CLER records with a 160 error code and a fail count of four or higher. A '160' error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment.

(j) The Carrier must demonstrate that it uses and shall use a statistically valid sampling technique to identify FEHB claims prior to or after processing that requires coordination of benefits with a third party payer or the Carrier shall pursue and provide evidence that it pursues all claims for coordination of benefits.

(k) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the

contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.
(l) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (k).

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS (JUL 2005) (FEHBAR 1652.222-70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) working days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15 percent or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10) Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11) Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12) Any fraud, embezzlement or misappropriation of FEHB funds; or

(13) Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, Renewal and Withdrawal of Approval.

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier will insert this clause in any subcontract or subcontract modification if the amount of the subcontract or modification charged to the FEHB Program (or in the case of a community-rated Carrier, applicable to the FEHB Program) equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7). [1]

SECTION 1.11
FEHB INSPECTION (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records – Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "Carrier."

---

[1] Section 811 of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. No. 115-91) increased the threshold for the application of the Truth in Negotiations Act from $750,000 to $2,000,000 for all contracts entered into after June 30, 2018. Based on this change in law, this contract subsection should be read to replace "$550,000" with "$2,000,000" and to replace "41 U.S.C. 254b(a)(7)" with "41 U.S.C. 3502(g)."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15*, Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS (JAN 2014)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure. OPM in its sole discretion, may order the Carrier to produce and distribute the agreed upon brochure text in a format and quantity approved by OPM, including an electronic 508 compliant brochure version, Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. 794d, for OPM's website. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure on a timely basis to new Enrollees and to other Enrollees upon their request. The Carrier shall also distribute the document(s) to Federal agencies and Tribal Employers to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version, CD, or other electronic media of the approved language. The Carrier may print additional FEHB brochures for distribution for its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

(e) The Carrier shall produce and make available an FEHB Summary of Benefits and Coverage (SBC).

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR ADVERTISING (JAN 1991) (FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material, including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the *FEHB Supplemental Literature Guidelines* which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.7002, as the primary guide in preparing material; further guidance is provided in the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation.* The guidelines are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to protect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense and in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all Enrollees of the Plan(s) that had been the subject of the original material.

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval.*

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL (JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
SUBCONTRACTS (JUL 2005) (FEHBAR 1652.244-70)

(a) The Carrier will notify the Contracting Officer in writing at least 30 days in advance of entering into any subcontract or subcontract modification, or as otherwise specified by this contract, if the amount of the subcontract or modification charged to the FEHB Program equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7). Failure to provide advance notice may result in a Contracting Officer's disallowance of subcontract costs or a penalty in the performance aspect of the Carrier's service charge. In determining whether the amount chargeable to the FEHB Program contract for a given subcontract or modification equals or exceeds the $550,000 threshold, the following rules apply:

(1) For initial advance notification, the Carrier shall add the total cost/price for the base year and all options, including quantity or service options and option periods.

(2) For contract modifications, options and/or renewals (e.g. evergreen contracts) not accounted for in paragraph (a)(1) of this clause, the Carrier shall provide advance notification if they cause the total price to equal or exceed the threshold. OPM's review will be of the modification(s), itself, but documentation for the original subcontract will be required to perform the review. The $550,000 threshold will be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act. All subcontracts or subcontract modifications that equal or exceed the threshold are subject to audit under FAR 52.215-2 "Audit and Records-Negotiations" if based on cost analysis or 48 CFR 1646.301 and 1652.246-70 "FEHB Inspection" if based on price analysis. [2]

(b) The advance notification required by paragraph (a) of this clause shall include the information specified below:

---

[2] Section 811 of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. No. 115-91) increased the threshold for the application of the Truth in Negotiations Act from $750,000 to $2,000,000 for all contracts entered into after June 30, 2018. Based on this change in law, this contract subsection should be read to replace "$550,000" with "$2,000,000" and to replace "41 U.S.C. 254b(a)(7)" with "41 U.S.C. 3502(g)."

PART II – BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 2015)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, Tribal Employees, annuitants, former spouses, and former employees and eligible members of their families who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 2020)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(b) In addition to providing benefits in accordance with (a) above, the Carrier shall be authorized to modify them as follows:

(1) To permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) To pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be

made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c)The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

(2)(i) An OPM requirement under (h)(1) is subject to ongoing review by OPM and the Carrier. Members must cooperate with the review process. If, in the Carrier's judgment, the conditions for the OPM requirement are no longer satisfied, the Carrier may request that OPM modify or terminate the requirement. OPM's decision to modify or terminate a requirement shall be subject to judicial review.

(ii) The Carrier agrees that its benefits as described in the brochure found at Appendix A, are reasonably and in good faith expected to result in coverage that satisfies Mental Health Parity and Addiction Equity Act requirements as defined in 45 C.F.R.146.136.

(i) In accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act, the Carrier shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require the Carrier to contract with any health care provider willing to abide by the terms and conditions for participation established by the carrier. Nothing in this section shall be construed as preventing a Carrier from establishing varying reimbursement rates based on quality or performance measures.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2016)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request, provided, however, that the Carrier shall not require Members to complete any form as a precondition of

receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9*, Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, Tribal Employer, organization or agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers' compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's Self Plus One or Self and Family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the child, then the Carrier may issue an identification card for the child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's Self Plus One or Self and Family enrollment. If a covered child is legally responsible, or if a covered

spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. 164.500 et seq.

(6) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(5) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments*. It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. If the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. In the case of fraud or abuse, the Carrier must coordinate with OPM OIG as required by Section 1.9 and OPM's Fraud, Waste and Abuse guidance. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3)(i) The Carrier may off-set future Benefits payable to the Member or to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(ii) Notwithstanding section 2.3(g)(3)(i), a Carrier may set up benefit off-sets to a provider less than 120 days after the first notice as long as the Carrier electing this option

continues to comply with any remaining applicable steps enumerated in this subsection 2.3(g) as part of the Carrier's effort to recover erroneous benefit payments.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; provided, however, that the Carrier may not commence an overpayment recovery lawsuit later than December 31 of the third year after the year in which the overpayment was discovered by the Carrier (except in cases where the False Claims Act, 31 U.S.C 3729, or another federal limitations period applies);

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent effort is required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.

(7) Suspend recovery efforts for a debt which is based upon a retroactive disenrollment that has been appealed under 5 C.F.R. 890.104 or a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(8)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments as described above.

(ii) Notwithstanding (g)(8)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);

(9) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

(10) If OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the Member, from the Member or, if to the provider, from the provider as specified in (g)(1) through (9).

(11) At the request of OPM, the Carrier shall provide evidence that it has taken the steps enumerated above in this subsection to promptly recover erroneous payments, including but not limited to overpayments related to Medicare coordination of benefits. OPM will review the Carrier's claims payments and procedures to validate the Carrier's prompt and diligent effort. The Contracting Officer may require the Carrier to establish and submit to the Contracting Officer a written corrective action plan.

(12) In compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.

(h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated

contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.

(j) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 2017)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage under the conditions and to the extent specified in the regulations or an extension of coverage under the conditions and to the extent specified below.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to obtain assistance from the Carrier for enrollment in a guaranteed issue non-group contract available in the Carrier's service area. In the event this 31-day temporary extension period provides insufficient opportunity for the Member to obtain non-group coverage with an effective date commencing before or immediately upon termination of group coverage, the Carrier may, on a case-by-case basis, provide an additional 29 days extension of coverage (not to exceed a total of 60 days) as appropriate to avoid an interruption in coverage. The Member must explain in writing the circumstances for seeking additional extension, and the Carrier must notify the Contracting Officer of any extension granted, or obtain prior approval of any request for an extension that the Carrier intends to deny.

(d) Costs associated with the additional extension of coverage not to exceed 60 days are allowable costs under the contract. Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

SECTION 2.5
SUBROGATION AND REIMBURSEMENT (JAN 2016)

(a) The Carrier must condition the extension of benefits and benefit payments to covered individuals on its rights to subrogation and reimbursement under 5 CFR 890.106.

(b) The Carrier shall subrogate and pursue reimbursement of FEHB claims if doing so would be in the best interests of the FEHBP.

(c) The Carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the Carrier. The Carrier has the right to file suit in federal court in order to enforce its rights to subrogation and reimbursement.

(d) The Carrier's subrogation and reimbursement policies for payments with respect to benefits shall be explained in the plan brochure.

(e) Subrogation recoveries and reimbursements may be reduced by any legal or subrogation and reimbursement vendor fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or subrogation and reimbursement vendor fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001) (FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary Carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated Carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 2022)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a or , 5 CFR Part 919, a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR Part 919.

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) Carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
CLAIMS PROCESSING (JAN 2011)

A standardized claims filing process shall be used by all FEHB Carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-04 form;

(3) The Carrier shall not use any unique provider claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the CMS 1500 form or the UB-04 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

SECTION 2.11
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2015)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers.

Carriers may use the Department of Veterans Affairs (VA) Medicare-equivalent remittance advice (MRA) when the form is submitted to determine the Plan's benefits payment for covered services provided to members who have Medicare as their primary payer, when Medicare does not pay the VA facility.

SECTION 2.12
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER
(JAN 2004)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior Carrier is discontinued in whole or in part, the gaining Carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.13
LARGE PROVIDER AGREEMENTS (OCT 2005) (FEHBAR 1652.204-74)

(a) Notification and Information Requirements. (1) The experience-rated Carrier must provide notice to the Contracting Officer of its intent to enter into or to make a significant modification of a Large Provider Agreement:

(i) Not less than 60 days before entering into any Large Provider Agreement; and

(ii) Not less than 60 days before exercising a renewal or other option, or significant modification to a Large Provider Agreement, when such action would result in total costs to the FEHB Program of an additional 20 percent or more above the existing contract. However, if a Carrier is exercising a simple renewal or other option contemplated by a Large Provider Agreement that OPM previously reviewed, and there are no significant changes, then a statement

to the effect that the renewal or other option is being exercised along with the dollar amount is sufficient notice.

(2) The Carrier's notification to the Contracting Officer must be in writing and must, at a minimum:

(i) Describe the supplies and/or services the proposed provider agreement will require;

(ii) Identify the proposed basis for reimbursement;

(iii) Identify the proposed provider agreement, explain why the Carrier selected the proposed provider, and what contracting method it used, where applicable, including the kind of competition obtained;

(iv) Describe the methodology the Carrier used to compute the provider's profit; and,

(v) Describe provider risk provisions.

(3) The Contracting Officer may request from the Carrier any additional information on a proposed provider agreement and its terms and conditions prior to a provider award and during the performance of the agreement. The Carrier may mark any information it deems confidential commercial information, and OPM will handle information so designated in accordance with relevant procedures set forth at 5 CFR Part 294.

(4) Within 30 days of receiving the Carrier's notification, the Contracting Officer will give the Carrier either written comments or written notice that there will be no comments. If the Contracting Officer comments, the Carrier must respond in writing within 10 calendar days, and explain how it intends to address any concerns.

(5) When computing the Carrier's service charge, the Contracting Officer will consider how well the Carrier complies with the provisions of this section, including the advance notification requirements, as an aspect of the Carrier's performance factor.

(6) The Contracting Officer's review of any Large Provider Agreement, option, renewal, or modification will not constitute a determination of the acceptability of the terms and conditions of any provider agreement or of the allowability of any costs under the Carrier's contract, nor will it relieve the Carrier of any responsibility for performing the contract.

(b) Records and Inspection. The Carrier must insert in all Large Provider Agreements the requirement that the provider will retain and make available to the Government all records relating to the agreement that support the annual statement of operations and Enrollee records--Retain for 6 years after the agreement term ends.

(c) Audit and Records - Negotiation. The provisions of FAR 52.215-2, "Audit and Records--Negotiation," when required, or FEHBAR 1652.246-70, "FEHB Inspection" apply to all experience-rated Carriers' Large Provider Agreements. The Carrier will insert the clauses at FAR 52.215-2, when applicable, or FEHBAR 1652.246-70 in all Large Provider Agreements. In FAR 52.215-2 the Carrier will substitute

(1) The term "Large Provider" for the term "Contractor" throughout the clause, and

(2) The term "Large Provider Agreement" for the term "Subcontracts" in paragraph (g) of FAR 52.215-2. The term "Contracting Officer" will mean the FEHB Program Contracting Officer at OPM. The Carrier will be responsible for ensuring the Large Provider complies with the provisions set forth in the clause.

(d) Prohibited Agreements. No provider agreement made under this contract will provide for payment on a cost-plus-a-percentage-of-cost basis.

(e) The Carrier will insert this clause, 1652.204-74, in all Large Provider Agreements.

SECTION 2.14
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2015)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.
(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage or may coordinate benefits subject to Contracting Officer approval.

SECTION 2.15
[RESERVED]

SECTION 2.16
[RESERVED]

SECTION 2.17
PART D CREDITABLE COVERAGE (JAN 2022)

The Carrier shall offer prescription drug coverage that is considered creditable prescription drug coverage under 42 CFR 423.56.

SECTION 2.18
SURPRISE BILLING (JAN 2022)

(a) The Carrier shall comply with requirements described in the provisions of sections 2799A–1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, and 2799A-7 and 2799A-8 of the Public Health Service Act, sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections.
(b) The Carrier's compliance with paragraph (a) will be concurrent and consistent with implementing regulations issued by the Departments of Health and Human Services, Labor, and the Treasury, subject to OPM regulation and FEHB contract terms.
(c) The Carrier's provider contracts must extend the provisions of sections 2799B–6, 2799B–8, and 2799B–9 of the Public Health Service Act to covered individuals in the same manner as such provisions apply to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer.
(d) Consistent with the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of Public Health Service Act section 2723 as well as 45 CFR Part 150 are inapplicable to the Carrier and Underwriter with respect to the Plan.

EXHIBIT O

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2024

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See our FEHB Facts for details. This Plan is accredited. See Section 1.

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 163

Enrollment codes for this Plan:
104 Standard Option - Self Only
106 Standard Option - Self Plus One
105 Standard Option - Self and Family
111 Basic Option - Self Only
113 Basic Option - Self Plus One
112 Basic Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 711.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 711.

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payment to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under contract (CS 1039) between the Blue Cross and Blue Shield Association and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our website, www.fepblue.org, or contact your Local Plan at the phone number appearing on the back of your ID card.

The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
750 9th Street NW
Washington, DC 20001-4524

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized in Section 2. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member; “we” means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other healthcare providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service Plan offers services through a PPO. This means that certain hospitals and other healthcare providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for Preferred retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also visit www.fepblue.org/provider/ to use our National Doctor & Hospital Finder. You can reach our website through the FEHB website, www.opm.gov/healthcare-insurance.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service phone number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other healthcare facilities, physicians, and other healthcare professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as "Preferred."** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

  Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see NSA in Section 4). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See Section 3 for the exceptions to this requirement.

  Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.
- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone number is shown on the back of your Service Benefit Plan ID card. You may also visit our website at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential.

Note: As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our website at www.fepblue.org.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only**, coinsurance does not begin until you have met your calendar year deductible. See Section 5(i) for information about the deductible and overseas benefits.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $350 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service phone number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers**. These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and the bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $250 for covered services subject to a $35 copayment. Even though our allowance may be $100, you still pay just the $35 copayment. Because of the agreement, your Preferred physician will not bill you for the $215 difference between your copayment and the bill.

- **Participating providers.** These types of **Non-preferred** providers have agreements with the Local Plan to limit what they bill our members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $250, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our $100 allowance ($35). Because of the agreement, your Participating physician will not bill you for the $150 difference between our allowance and the bill.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our website, www.fepblue.org, or call us at the customer service phone number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

  Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances described in the *No Surprises Act*, later in this section). For example, you see a Non-participating physician who charges $250. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the $100 Plan allowance or $35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $150 difference between our allowance and the bill. This means you would pay a total of $185 ($35 + $150) for the Non-participating physician's services, rather than $15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

- **Remember, under Basic Option you must use Preferred providers in order to receive benefits. There are no benefits for care performed by Participating and Non-participating providers. See Section 3 for exceptions under *What you must do to get covered care*.**

The following examples illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/ Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only**.

Basic Option benefit levels for physician care begin in Section 5(a) and outpatient hospital or ambulatory surgical facility care begins in Section 5(c).

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $250 and the Plan allowance is $100.

EXAMPLE

Preferred Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe: Coinsurance: 15% of our allowance: 15
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 150
TOTAL YOU PAY: $185

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance ($100), which you would pay in full, would count toward your deductible.

You should also see *Important Notice About Surprise Billing – Know Your Rights* in this section that describes your protections against surprise billing under the No Surprises Act.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges $5,000. The Plan allowance is $2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is $2,500 when the services are provided at a Non-member facility.

EXAMPLE

Preferred Ambulatory Surgical Facility Standard Option
Facility’s charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe: Coinsurance: 15% of our allowance: 435
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility’s charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe: Coinsurance: 35% of our allowance: 1,015
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $1,015

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have an acute chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to Section 5(h). Contact us at the phone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your healthcare needs.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
  - **You must use Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.

Standard and Basic Option

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Professional Services	**Standard Option**	**Basic Option**
We cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Services provided by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) Note: To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance use disorder phone number on the back of your ID card. Note: See Sections 5(a) and 5(f) for our coverage of smoking and tobacco cessation treatment. Note: See Section 5(a) for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	Preferred: $30 copayment for the visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: $35 copayment per visit Participating/Non-participating: You pay all charges
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a). Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• Inpatient professional services	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (no deductible) Non-participating: 35% of the Plan allowance (no deductible), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Inpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests Note: Inpatient care to treat substance use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
Precertification prior to admission is required. We cover inpatient care provided and billed by an RTC when the care is medically necessary for the treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long-term care; and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Continued from previous page: Note: Non-member facilities must, prior to admission, agree to abide by the terms established by the Local Plan for the care of the particular member and for the submission and processing of related claims.	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Partial hospitalization • Intensive outpatient treatment	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $35 copayment per day per facility Member/Non-member: You pay all charges
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member/Non-member: Nothing
Not Covered (Inpatient or Outpatient)	**Standard Option**	**Basic Option**
• *Educational or other counseling or training services* • *Services performed by a noncovered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described in Sections 5(a) and 5(e)*	*All charges*	*All charges*

Not Covered (Inpatient or Outpatient) - continued on next page

Benefit Description	You Pay	
Not Covered (Inpatient or Outpatient) (cont.)	**Standard Option**	**Basic Option**
• *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described in this section when they are provided and billed by a covered professional provider acting within the scope of their license.* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *Light boxes* • *Custodial or long-term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*	*All charges*	*All charges*

Section 8. The Disputed Claims Process

Please follow this Federal Employees Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please call your Plan's customer service representative at the phone number found on your enrollment card, our brochure, or our website (www.fepblue.org).

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please call us at the customer service phone number on the back of your Service Benefit Plan ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 1, 1900 E Street NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service phone number on the back of your Service Benefit Plan ID card. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 1 at 202-606-0727 between 8 a. m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about Plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JANE DOE, *on behalf of Baby Doe, a minor*, and PATRICIA CAVALLARO-KEARINS, *on behalf of themselves and all others similarly situated*, Plaintiffs, -v- ANTHEM HEALTHCHOICE ASSURANCE, INC., *doing business as* Anthem Blue Cross and Blue Shield *and* Anthem Blue Cross, Defendant.	24 Civ. 8012 (JPC) OPINION AND ORDER

JOHN P. CRONAN, United States District Judge:

Plaintiffs Jane Doe and Patricia Cavallaro-Kearins allege that Defendant Anthem HealthChoice Assurance, Inc. ("Anthem") publishes inaccurate directories of mental-health providers. Plaintiffs claim that Anthem's use of these directories, known as "ghost networks," violates New York State common and statutory law. But Plaintiffs' state-law claims are expressly preempted by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901 *et seq.* So the Court grants Anthem's motion to dismiss for failure to state a claim.

I. Background

A. Facts[1]

Anthem is a health insurance company that offers plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program. Compl. ¶ 20. One such employee is Plaintiff Patricia Cavallaro-Kearins, who has been a member of Anthem's Blue Cross Blue Shield Service Benefit Plan FEP Blue Standard Option ("Standard Option Plan") since January 1, 2019. *Id.* ¶¶ 19, 70. Plaintiff Jane Doe is another; she and her daughter, Baby Doe, have been covered by the Standard Option Plan for over five years. *Id.* ¶¶ 17-18, 85.

The Standard Option Plan stems from the statutory framework set forth by FEHBA. Through FEHBA, Congress has "authorized the Office of Personnel Management (OPM) to contract with private carriers for federal employees' health insurance." *Coventry Health Care of Mo., Inc. v. Nevils*, 581 U.S. 87, 90 (2017) (citing 5 U.S.C. § 8902(a), (d)). OPM has contracted with the Blue Cross and Blue Shield Association ("BCBSA") to create the Standard Option Plan, which Anthem administers in New York. *See* Stuhan Decl., Exh. B ("OPM-BCBSA Contract") § 4.3; Compl. ¶¶ 21-22, 117. As FEHBA provides, contracts "shall contain a detailed statement of benefits" approved by OPM, 5 U.S.C. §§ 8902(d), 8907, also known as a brochure, and under

[1] The facts contained in this section, which are assumed true solely for purposes of this Opinion and Order, are taken from Plaintiffs' Complaint, Dkt. 1 ("Compl."). *See Interpharm, Inc. v. Wells Fargo Bank, Nat'l Ass'n*, 655 F.3d 136, 141 (2d Cir. 2011) (explaining that on a motion to dismiss pursuant to Rule 12(b)(6), the court must "assum[e] all facts alleged within the four corners of the complaint to be true, and draw[] all reasonable inferences in plaintiff's favor"). The Court also considers the contracts and statements of benefits attached to the Declaration of Brendan G. Stuhan, Dkt. 26 ("Stuhan Decl."), which are incorporated by reference into the Complaint, *see, e.g.*, Compl. ¶¶ 71, 117-118, 152-154, 228-232, 240, 253, 262-263, 269. *See Kleinman v. Elan Corp.*, 706 F.3d 145, 152 (2d Cir. 2013); *La Vigne v. Costco Wholesale Corp.*, 284 F. Supp. 3d 496, 502 (S.D.N.Y. 2018), *aff'd*, 772 F. App'x 4 (2d Cir. 2019). "Plaintiffs have no objection to this Court's considering, as incorporated by reference," those documents. Dkt. 29 ("Opposition") at 2 n.1.

the OPM-BCBSA Contract, carriers "shall provide the benefits as described in the agreed upon brochure text," OPM-BCBSA Contract § 2.2(a). *See also Empire HealthChoice Assurance, Inc. v. McVeigh* ("*McVeigh II*"), 547 U.S. 677, 684 (2006) ("Each enrollee, as FEHBA directs, receives a statement of benefits conveying information about the Plan's coverage and conditions.").

The Statement of Benefits explains that under the Standard Option Plan, Anthem has contracted and set negotiated rates with certain providers. Stuhan Decl., Exh. O ("2024 Statement of Benefits") at 12. "[T]hese providers qualify as 'in-network' providers, accept lower payments from the insurer, and agree to charge members an agreed-upon discounted amount." Compl. ¶ 104. By contrast, "[m]embers who see providers not within Anthem's network—'out-of-network' providers—will be subjected to a variety of additional costs: some known, some unknown." *Id.* ¶ 107; *see* 2024 Statement of Benefits at 13 (warning that under the Standard Option Plan, one's "out-of-pocket costs may be substantially higher when" seeing out-of-network providers). The Statement of Benefits also sets out the Standard Option Plan's coverage for different types of care, including mental-health care, along with the amounts the Plan will pay for in-network and out-of-network mental-health providers. 2024 Statement of Benefits at 93-97. And the Statement of Benefits contains a link where enrollees can locate in-network mental-health providers. *Id.* at 94; Compl. ¶ 71.

The OPM-BCBSA Contract—which creates the Standard Option Plan and incorporates the Statement of Benefits—includes several provisions concerning accuracy. For instance, carriers must use the OPM-approved Statement of Benefits "verbatim," OPM-BCBSA Contract § 1.13(c), and agree that "any advertising material . . . shall be truthful and not misleading," *id.* § 1.14(a). Violations of the latter clause are subject to "[c]orrective action[s]" taken "by OPM" like calling for the carrier to "cease and desist" publishing the misleading material and to "issue corrections"

of the material. *Id.* § 1.14(c)(1)-(2). The contract also requires Anthem to comply with certain provisions of the No Suprises Act ("NSA"), Pub. L. 116-260, § 116, 134 Stat. 1182, 2878-89 (2020), under which it must ensure that a plan's provider-directory information is accurate. OPM-BCBSA Contract § 2.18(a); Compl. ¶ 118; *see* 42 U.S.C. § 300gg-115(a). To ensure accuracy, Anthem is obligated to update its directory every ninety days, remove providers whose directory information it is unable to verify, and update the directory within two days of receiving new information from a provider. 42 U.S.C. § 300gg-115(a)(2); *see* Compl. ¶¶ 118-121. The NSA further specifies that if a provider directory inaccurately lists a provider as in-network, Anthem may only charge the enrollee the amount that it would have if the provider actually had been in-network. 42 U.S.C. § 300gg-115(b).

According to Plaintiffs, Anthem both keeps an inaccurate mental-health provider directory and gives consumers "deceptive and materially misleading marketing and program materials," which "promise mental health benefits and a robust network of in-network providers." Compl. ¶¶ 126-128, 150-177. Specifically, Plaintiffs allege that Anthem's directory lists providers who are not actually in-network or are not accepting new patients for outpatient mental-health services, and includes inaccurate information for those who are. *Id.* ¶¶ 6, 126-128, 140-149. Anthem, in other words, allegedly maintains a "ghost network." *Id.* ¶¶ 1-2, 51-69 (describing ghost networks generally). And because Anthem maintains a ghost network, Plaintiffs claim, the materials associated with the Standard Option Plan—including the Statement of Benefits—are "deceptive." *Id.* ¶¶ 10, 152, 170.

Plaintiffs point to harm they have suffered from Anthem's ghost network. Cavallaro-Kearins, for instance, sought a licensed provider to treat her ADHD and anxiety, but "could not find a single available, in-network provider using Anthem's online provider directory." *Id.* ¶¶ 73-

74. Because there were no in-network providers close by, Cavallaro-Kearins resorted to paying for an out-of-network psychiatrist, costing her thousands of dollars for which she has received minimal reimbursement from Anthem. *Id.* ¶¶ 76-82. As those costs were unsustainable, she stopped seeing that out-of-network psychiatrist, and only recently has found an in-network nurse practitioner—although in-network psychiatrists remain unavailable. *Id.* ¶¶ 82-84. The Does, for their part, have yet to find an in-network provider to treat Baby Doe's autism spectrum disorder, and because Jane Doe is unable to financially afford out-of-network treatment, Baby Doe has foregone care. *Id.* ¶¶ 88-96.

B. Procedural History

Plaintiffs filed suit against Anthem and a related entity[2] on October 22, 2024. Dkt. 1. The Complaint asserts six state-law causes of action: breach of contract by Anthem's failure to comply with various federal laws as required under the OPM-BCBSA Contract, Compl. ¶¶ 227-233; violation of the New York General Business Law ("GBL") Section 349, *id.* ¶¶ 234-246; violation of GBL Section 350, *id.* ¶¶ 247-259; violation of New York Insurance Law Section 4226, *id.* ¶¶ 260-266; fraudulent misrepresentation, *id.* ¶¶ 267-276; and unjust enrichment, *id.* ¶¶ 277-284. The Complaint also includes class-action allegations, as Plaintiffs bring this suit both individually and on behalf of a class. *Id.* ¶¶ 216-226. Among other things, the Complaint requests declaratory relief that Anthem's "actions violate federal law" (namely the NSA), injunctive relief prohibiting Anthem "from continuing to violate federal law," and damages. *Id.* at 70-71.

On February 21, 2025, the Court set a briefing schedule on Anthem's anticipated motion to dismiss. Dkt. 19. Consistent with that briefing schedule, on March 28, 2025, Anthem moved

[2] Plaintiffs have since voluntarily dismissed their claims against the related entity, Anthem HP, LLC. Dkt. 15.

to dismiss Plaintiffs' Complaint for failure to state a claim. Dkt. 25 ("Motion"); Stuhan Decl. After Anthem filed that motion, the parties jointly moved to stay discovery pending the motion's resolution. Dkt. 27. The Court granted the joint motion and stayed discovery on April 3, 2025. Dkt. 28. Plaintiffs responded to the motion to dismiss on May 2, 2025. Opposition. Anthem replied on May 30, 2025. Dkt. 30 ("Reply").

II. Standard of Review

To survive a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim, "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A claim is plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* A complaint's "[f]actual allegations must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555. Although a court must "accept[] as true the factual allegations in the complaint and draw[] all inferences in the plaintiff's favor," *Biro v. Condé Nast*, 807 F.3d 541, 544 (2d Cir. 2015), it need not "accept as true legal conclusions couched as factual allegations," *LaFaro v. N.Y. Cardiothoracic Grp.*, *PLLC*, 570 F.3d 471, 475-76 (2d Cir. 2009).

III. Discussion

Anthem argues that all of Plaintiffs' claims are expressly and implicitly preempted by FEHBA, that all of Plaintiffs' claims must be dismissed because Plaintiffs have failed to exhaust their administrative remedies, that Plaintiffs' breach-of-contract claim fails under third-party beneficiary principles, and that Plaintiffs are not entitled to benefit-of-the-bargain damages should

any of their claims survive. Motion at 8-24. Because the Court agrees that FEHBA expressly preempts Plaintiffs' claims, it need not consider Anthem's other arguments.

Under the doctrine of preemption, Congress "may exercise its constitutionally delegated authority to set aside the laws of a State," meaning that "[w]hen federal law preempts nonfederal law, the Supremacy Clause requires courts to follow federal, not state, law." *Buono v. Tyco Fire Prods., LP*, 78 F.4th 490, 495 (2d Cir. 2023) (internal quotation marks omitted). There are generally "three forms" of preemption, one of which is "express preemption, where Congress has expressly preempted local law." *Id.* (citation omitted). When "a federal law contains an express preemption clause," courts "focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' preemptive intent," the ultimate objective of the preemption inquiry. *Id.* (internal quotation marks omitted). While the existence of an express-preemption clause "does not immediately end the inquiry because the question of the substance and scope of Congress' displacement of state law still remains," neither is there "any presumption against preemption when a statute contains an express-preemption clause." *Id.* at 495-96 (citation modified).

FEHBA contains an express-preemption clause. Under that clause, "[t]he terms of any contract . . . which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law . . . which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). As stated, Section 8902(m)(1) sets out two preemption requirements: (1) the dispute must implicate contractual terms "which relate to the nature, provision, or extent of coverage or benefits," and (2) the state law which those terms would preempt must "relate[] to health insurance or plans." *Nevils*, 581 U.S. at 94-95 (quoting 5 U.S.C. § 8902(m)(1)).

Plaintiffs do not contest that this dispute implicates contractual terms relating to the nature, provision, or extent of coverage or benefits. *See* Opposition at 5 (arguing only that Plaintiffs' claims "do not satisfy the second preemption precondition"). Nor could they: the entire dispute centers on provisions of the OPM-BCBSA Contract and incorporated Statement of Benefits that implicate coverage for mental-health treatment and the benefits associated with that coverage. These provisions include the Statement of Benefits' description of mental-health coverage and benefits along with a link to in-network providers, 2024 Statement of Benefits at 93-97, and the contractual clauses concerning the accuracy of statements made about coverage and benefits, OPM-BCBSA Contract §§ 1.14 (governing materially misleading statements), 2.18(a) (incorporating the NSA). The terms of the OPM-BCBSA Contract at issue thus "relate to the nature, provision, or extent of coverage or benefits." 5 U.S.C. § 8902(m)(1).

The parties vigorously contest, however, whether Plaintiffs' state-law claims relate to health insurance or plans. Plaintiffs assert that "laws of general application—*i.e.*, laws that are not specific to the regulation of health insurance," like "generally applicable contract, tort, and consumer-protection law[s]"—"are not preempted by FEHBA." Opposition at 4. On Plaintiffs' reading of Section 8902(m)(1), only those state laws that "specifically" and exclusively relate to health insurance or plans are preempted. *Id.* at 10-11. Anthem, for its part, argues that "state laws of general application that do not reference health insurance or plans still trigger FEHBA's second requirement for preemption." Motion at 12. The Court agrees with Anthem: because even the generally applicable state-law claims at issue in this case "relate[] to health insurance or plans," 5 U.S.C. § 8902(m)(1), FEHBA expressly preempts those claims.

Plaintiffs' primary argument is that the Second Circuit has already held that generally applicable laws necessarily do not relate to health insurance or plans. *See* Opposition at 4-10

(citing *Empire HealthChoice Assurance, Inc. v. McVeigh* ("*McVeigh I*"), 396 F.3d 136, 145-46 (2d Cir. 2005)). In *McVeigh I*, the Second Circuit considered whether there was federal question jurisdiction under 28 U.S.C. § 1331 over an insurance company's claim that an enrollee had breached a subrogation and reimbursement provision in the statement of benefits. 396 F.3d at 138-40. As the Second Circuit explained, "FEHBA does not provide a federal statutory cause of action for insurance carriers to vindicate their rights under FEHBA-authorized contracts," so federal question jurisdiction over the dispute existed "only if federal common law govern[ed] [the company's] claims." *Id.* at 140. The court held that federal common law did not govern the insurance company's claims because the company had "not demonstrated an actual, significant conflict between New York state law and the federal interests underlying FEHBA." *Id.* at 140-42 (internal quotation marks omitted). The court also rejected the argument that Section 8902(m)(1)—FEHBA's express-preemption provision—"authorizes by itself the exercise of federal jurisdiction," concluding that FEHBA does not "reveal[] a congressional objective to resolve all manner of breach of contract suits relating to the [insurance plan] in federal court." *Id.* at 145-149.

The *McVeigh I* majority further discussed the meaning of Section 8902(m)(1). Guided by a "presumption against federal preemption," it rejected the dissent's suggestion "that the phrase 'state or local law . . . which relates to health insurance or plans' encompasses laws of general application that make absolutely no reference to health insurance or plans but are used in a given case to construe or enforce FEHBA plans." *Id.* at 145-46 (internal quotation marks omitted). That was because such a reading would give an "excessively broad interpretation" to the phrase "relate to" and render Section 8902(m)(1)'s "second limiting condition" largely "meaningless." *Id.* at 146-48. The kind of state law that relates to health insurance or plans, the majority reasoned, is

one that "explicitly refers to or discusses health insurance or plans," like a "state health insurance law." *Id.* at 145 n.9 & 148 (citation modified). But "[w]ithout any showing that the dispute implicates a specific state law or state common-law principle 'relat[ing] to health insurance,' § 8902(m)(1) does not authorize federal preemption of state law *in this case*." *Id.* at 145 (emphasis added). And "even if" it did, that would be "insufficient to create federal jurisdiction," because the "well-pleaded complaint rule requires that the complaint itself arise under federal law in order for there to be jurisdiction," and the insurance company's claims arose "under state law," not federal common law. *Id.* at 150.

As the above indicates, this discussion about Section 8902(m)(1)'s meaning was not necessary to the Second Circuit concluding that federal question jurisdiction was lacking. In affirming *McVeigh I*, the Supreme Court confirmed as much. The Court first agreed with the Second Circuit's federal-common-law holding that the insurance company had "not demonstrated a significant conflict between an identifiable federal policy or interest and the operation of state law," so there was "no cause to displace state law, much less to lodge th[e] case in federal court." *McVeigh II*, 547 U.S. at 690-93 (citation modified). And the Court agreed with the Second Circuit that Section 8902(m)(1), "FEHBA's preemption prescription," was not "a jurisdiction-conferring provision." *Id.* at 697. Like the Second Circuit, the Court explained that "Section 8902(m)(1)'s text does not purport to render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans." *Id.* at 698. "[I]f Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear," which it had "not done" with FEHBA. *Id.* But unlike the Second Circuit, the Court did not elaborate on whether state laws of general application could still relate to health insurance or plans, because "*even if FEHBA's preemption provision*

reaches contract-based reimbursement claims, that provision is not sufficiently broad to confer federal jurisdiction." *Id.* (emphasis added). So all the Court "extract[ed] from § 8902(m)(1)" was "no prescription for federal-court jurisdiction." *Id.* at 699.

It is without doubt that "the Supreme Court ha[d] not endorsed" in *McVeigh II* the Second Circuit's discussion of generally applicable state laws in *McVeigh I*. *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 749 F. Supp. 3d 456, 471 (S.D.N.Y. 2024). Plaintiffs try to characterize the Second Circuit's language as an alternative holding that survives the Supreme Court's affirmance on other grounds. Opposition at 6-7 (citing *In re Arab Bank, PLC Alien Tort Statute Litig.*, 808 F.3d 144, 151 (2d Cir. 2015)). But this misses the point: a statement that is unnecessary to a court's conclusion that it lacks jurisdiction is necessarily *dictum*, not an "alternative holding." *Klein ex rel. Qlik Techs., Inc. v. Qlik Techs., Inc.*, 906 F.3d 215, 227 & n.7 (2d Cir. 2018). Such observations, then, "do not bind the district court." *United States v. Giffen*, 473 F.3d 30, 44 (2d Cir. 2006). Indeed, Anthem correctly points out that "Plaintiffs fail to cite a single case holding that [*McVeigh I*] precludes preemption of laws of general application." Reply at 6. Courts in this Circuit, rather, have concluded that "the statements in *McVeigh I* regarding the scope of FEHBA preemption are *dicta* and do not control the Court's analysis." *Mahajan v. Blue Cross Blue Shield Ass'n*, No. 16 Civ. 6944 (PKC), 2017 WL 4250514, at *8 (S.D.N.Y. Sept. 22, 2017); *see Calingo v. Meridian Res. Co.*, No. 11 Civ. 628 (VB), 2011 WL 3611319, at *9 (S.D.N.Y. Aug. 16, 2011) (deeming as "*dicta*" *McVeigh I*'s statements "addressed to the second prong of the preemption analysis—whether the state law relates to health insurance"); *Emergency Physician Servs. of N.Y.*, 749 F. Supp. 3d at 471 (similar); *see also Liberty Wellness Chiropractic v. Empire HealthChoice HMO, Inc.*, No. 21 Civ. 2132 (CM), 2023 WL 1927828, at *8-9 (S.D.N.Y.

Feb. 10, 2023) (collecting post-*McVeigh* cases holding that generally applicable state-law claims are preempted by FEHBA). This Court agrees that it is not bound by *McVeigh I* on this question.

Of course, that *McVeigh I*'s treatment of Section 8902(m)(1)'s second prong is *dicta* does not give the Court "license to cavalierly disregard it." *Imhof v. N.Y.C. Hous. Auth.*, 792 F. Supp. 3d 501, 511 (S.D.N.Y. 2025) (internal quotation marks omitted). Yet while "Second Circuit *dictum* warrants substantial deference from this Court," here, there are "compelling argument[s]" to depart from *McVeigh I*. *Id.* at 511-12 (internal quotation marks omitted).

Most notably, intervening Supreme Court caselaw has cast considerable doubt on the Second Circuit's *dicta*.[3] In *Coventry Health Care of Missouri, Inc. v. Nevils*, the Supreme Court considered whether "FEHBA's express-preemption prescription, § 8902(m)(1), override[s] state law prohibiting subrogation and reimbursement." 581 U.S. at 90-91. The Court explained that this was not the "discrete question" it had considered in *McVeigh II*: "whether 28 U.S.C. § 1331 gives federal courts subject-matter jurisdiction over FEHBA reimbursement actions." *Id.* at 97. As the Supreme Court recounted, in rejecting the assertion "that § 8902(m)(1) itself conferred federal jurisdiction," the *McVeigh II* Court "had no cause to consider § 8902(m)(1)'s text, context, and purpose," because "even if FEHBA's preemption provision reaches contract-based reimbursement claims," that "answer made no difference to the question there presented." *Id.* (citation modified).

[3] Because *McVeigh I* did not "unequivocally h[o]ld" that Section 8902(m)(1) fails to reach state laws of general application, Plaintiffs' reliance on the Second Circuit's instruction that "a District Court must follow controlling precedent—even precedent the District Court believes may eventually be overturned—" is inapposite. *Packer ex rel. 1-800 Flowers.com, Inc. v. Raging Cap. Mgmt., LLC*, 105 F.4th 46, 50, 53 (2d Cir. 2024) (internal quotation marks omitted); *see* Opposition at 9-10.

Considering Section 8902(m)(1)'s text, context, and purpose, the *Nevils* Court undercut the Second Circuit's *McVeigh I* language in at least three ways. First, unlike the Second Circuit, the Supreme Court declined to "apply a presumption against preemption" to Section 8902(m)(1). *Compare Nevils*, 581 U.S. at 97, *with McVeigh I*, 396 F.3d at 145 (invoking "the presumption against federal preemption that should guide our analysis in this case"). Second, the state-law prohibition against subrogation and reimbursement at issue in *Nevils* "had nothing in particular to do" with health insurance or plans. *Mahajan*, 2017 WL 4250514, at *8. While Plaintiffs correctly point out that the Supreme Court did not expressly "assess the second preemption requirement in light of the parties' agreement that it was satisfied," Opposition at 9; *see Nevils*, 581 U.S. at 94-95, that widespread assumption remains "[a]nother clue that the state law at issue need not relate specifically to health insurance or plans," *Mahajan*, 2017 WL 4250514, at *8. *See also Ray v. Tabriz*, No. 23-cv-1467, 2025 WL 306175, at *2 (N.D. Ill. Jan. 27, 2025) (concluding "post-*Nevils*" that "even a generally applicable law can 'relate to health insurance or plans' in a case like this one where it is being used to limit a health insurer's reimbursement"). Third, and most importantly, the *Nevils* Court adopted the broad reading of the "expansive phrase 'relate to,'" *Nevils*, 581 U.S. at 95, that the Second Circuit rejected in *McVeigh I*. *Compare id.* at 95-96 ("We have 'repeatedly recognized' that the phrase 'relate to' in a preemption clause 'express[es] a broad pre-emptive purpose.'" (quoting *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992))), *with McVeigh I*, 396 F.3d at 147-48 (rejecting an "excessively broad interpretation" of Section 8902(m)(1) because the "many Supreme Court and Second Circuit cases constru[ing] the term 'relates to' quite broadly" did "not involve FEHBA"). Since "Congress characteristically employs the phrase to reach any subject that has 'a connection with, or reference to,' the topics the statute enumerates," the *Nevils* Court dismissed the argument "that Congress intended to preempt

only state coverage requirements," as opposed to subrogation-and-reimbursement requirements. 581 U.S. at 96 (quoting *Morales*, 504 U.S. at 384) (emphasis added).

As other courts have recognized, that adoption both neutralizes *McVeigh I* and explains in the first instance why laws of general application are not categorically excluded from Section 8902(m)(1)'s preemptive reach. For example, the Honorable P. Kevin Castel has explained post-*Nevils* that "[t]here is nothing in the text of section 8902(m)(1) that limits its application to state laws that specifically, explicitly or expressly relate to health insurance or plans." *Mahajan*, 2017 WL 4250514, at *8. Rather, "[s]tate laws of general application, including common law principles, can directly and significantly impact health insurance plans." *Id.* The Fifth Circuit agrees: while that court acknowledged that common-law tort and contract claims "do not specifically relate to health insurance, . . . preemption reaches even a state's general laws when their *application* relates to the scope or administration of federal healthcare plans." *Gonzalez v. Blue Cross Blue Shield Ass'n*, 62 F.4th 891, 904 (5th Cir. 2023). That is because *Morales*—the same case the Supreme Court relied on in *Nevils* to describe FEHBA's "broad pre-emptive purpose," 581 U.S. at 95-96—"squarely rejected the notion that 'laws of general applicability' escape the broad 'sweep of the "relating to" language.'" *Gonzalez*, 82 F.4th at 904 (quoting *Morales*, 504 U.S. at 386). And for the exact same reasons, the Sixth Circuit recently rejected the "suggest[ion] that FEHBA does not preempt state laws of general application," albeit in the related-but-distinct context of federal officer removal. *Ohio ex rel. Yost v. Ascent Health Servs., LLC,* 165 F.4th 999, 1012 (6th Cir. 2026).

All that is left, then, is Plaintiffs' backup argument that "even if this Court considered the matter afresh, the Second Circuit was clearly correct that only its reading gives 'independent meaning' to the second condition for FEHBA preemption." Opposition at 10-11 (quoting *McVeigh*

I, 396 F.3d at 146). Put differently, Plaintiffs are of the view that under Anthem's reading of the phrase "relates to health insurance or plans," if that phrase were "stricken" from Section 8902(m)(1), "the statute would already preempt state or local laws 'that relate to the nature, provision, or extent of coverage or benefits' provided to federal employees under FEHBA contracts." *Id.* at 10 (quoting 5 U.S.C. § 8902(m)(1)). But even in *McVeigh I*, the majority recognized that "the second condition might have independent meaning in a dispute that (1) centers on contract terms specifically relating to health coverage but (2) does not involve the enforcement or construction of those contract terms." 396 F.3d at 146. That is evident from Section 8902(m)(1)'s plain meaning: the statute does not "preempt[] *all* state laws," but only those that "relate[] to health insurance or plans." *Mahajan*, 2017 WL 4250514, at *8 ("The phrase 'relates to health insurance or plans' limits the scope of preemption."). As Anthem puts it, "[t]he first condition describes what does the preempting (contract terms relating to coverage or benefits) while the second condition describes what is preempted (state law relating to health insurance or plans)." Reply at 5-6. So even where a case implicates contract terms relating to coverage or benefits, those terms preempt only state laws that relate to health insurance or plans. *See McVeigh I*, 396 F.3d at 158 (Raggi, J., dissenting) ("[W]here general state or local law affects FEHBA coverage or benefits only tangentially, without attempting to construe or enforce those plan terms, preemption may not be warranted.").

Nor is it so "difficult . . . to imagine such a case." *Contra id.* at 146 (majority op.). For instance, the Ninth Circuit has held that state-law medical malpractice claims do not relate to health insurance or plans even if the plaintiff's claim "referenc[es] the existence of a benefit plan." *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 849-51 (9th Cir. 2002) (distinguishing "between claims based on a denial of benefits, which are preempted, and claims based on medical

malpractice, which are not"). To be sure, these cases are likely the exception and not the rule. But while those cases may indeed be rare, such rarity is consistent with Section 8902(m)(1)'s "statutory context and purpose." *Nevils*, 581 U.S. at 96. "FEHBA concerns benefits from a federal health insurance plan for federal employees that arise from a federal law in an area with a long history of federal involvement," and there are "[s]trong and distinctly federal interests . . . in uniform administration of the program, free from state interference, particularly in regard to coverage, benefits, and payments." *Id.* (citation modified). Indeed, "one of Congress' stated goals for FEHBA and the preemption provision in particular[] was to ensure the uniform administration of FEHBA benefit plans across the country." *Mahajan*, 2017 WL 4250514, at *9. So there is nothing incongruous about Section 8902(m)(1) "displac[ing]" state law—"whether consistent or inconsistent with federal plan provisions"—in most cases. *McVeigh II*, 547 U.S. at 686.

All told, in this Circuit there is no categorical rule preventing state laws of general application from relating to health insurance or plans under FEHBA. *See, e.g.*, *Mahajan*, 2017 WL 4250514, at *7-9; *Liberty Wellness Chiropractic*, 2023 WL 1927828, at *8-9; *Emergency Physician Servs. of N.Y.*, 749 F. Supp. 3d at 471-72; *see also Gonzalez*, 62 F.4th at 904-05; *Ascent Health Servs.*, 165 F.4th at 1012; *Ray*, 2025 WL 306175, at *2. Instead, "preemption reaches even a state's general laws when their *application* relates to the scope or administration of federal healthcare plans." *Gonzalez*, 62 F.4th at 904; *see Mahajan*, 2017 WL 4250514, at *8 ("State laws of general application, including common law principles, can directly and significantly impact health insurance plans.").

With the proper understanding of Section 8902(m)(1) in mind, the Court finds that each of Plaintiffs' state-law claims "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). Start with the most obvious: Plaintiffs' fourth cause of action, for a violation of New York Insurance

Law Section 4226. Compl. ¶¶ 260-266. That statute prohibits an "insurer . . . in . . . the business of life, or accident *and health insurance*" from "misrepresenting the terms, benefits, or advantages of any of its policies or contracts." N.Y. Ins. L. § 4226(a)(1) (emphasis added). Such a claim expressly relates to health insurance and plans.

Plaintiffs' other claims just as clearly—if not expressly—relate. *See Mahajan*, 2017 WL 4250514, at *8 ("There is nothing in the text of section 8902(m)(1) that limits its application to state laws that specifically, explicitly or expressly relate to health insurance or plans."). Indeed, this case is all but identical to *Mahajan*. There, the plaintiff alleged that the insurance carrier "misrepresented the scope of its preferred provider network and the availability of in-network certified lactation consultants[,] inducing her to enroll in defendant's health benefits plan and suffer damages." *Id.* at *1. Based on the "defendant's alleged misrepresentations regarding the availability of in-network lactation consultants and the payments required for those services," the plaintiff asserted claims for "deceptive business practices and misrepresentations in violation of" GBL Sections 349 and 350, along with common-law fraud—just as Plaintiffs do here. *Compare id.* at *5, *with* Compl. ¶¶ 234-246 (GBL Section 349), 247-259 (GBL Section 350), 267-276 (fraudulent misrepresentation). Judge Castel concluded that "[a]s applied [t]here," New York "common law and consumer fraud statutes ha[d] a direct and significant impact on FEHBA benefit plans and their administration in that they seek to regulate the disclosures made about those plans." *Mahajan*, 2017 WL 4250514, at *9. So too here. *See, e.g.*, Compl. ¶ 242 ("Omitted and concealed from the representations were material and relevant facts that Plaintiffs and Class members would have used in selecting their health insurance plan."). And while Plaintiffs here raise breach-of-contract and unjust-enrichment claims not raised in *Mahajan*, the same is true of those claims. *See id.* ¶¶ 232 (alleging that Anthem violated federal laws, including the NSA, "and, by extension, its

contractual obligations to Plaintiffs and the Class" by "failing to consistently provide an accurate network directory and failing to ensure mental health network adequacy"), 278 (alleging that Anthem "has been and continues to be significantly and unjustly enriched because of its inaccurate and inadequate mental health provider network that violates federal law").[4] The Court thus follows Judge Castel's well-reasoned conclusion that the "state common law principles and consumer protection statutes invoked by [Plaintiffs] sufficiently relate to health insurance or plans to trigger preemption." *Mahajan*, 2017 WL 4250514, at *9 (citation modified).

* * *

The Court appreciates Plaintiffs' frustration with ghost networks, a frustration that their Complaint suggests is shared by Congress and state authorities. *See* Compl. ¶¶ 36-63. But "under the statutory and regulatory regime" that this Court is "bound to apply, no relief is available." *Gonzalez*, 62 F.4th at 905. Because Plaintiffs' claims are all "expressly preempted" by FEHBA, they "must be dismissed." *Mahajan*, 2017 WL 4250514, at *9.

[4] In *Emergency Physician Services of New York*, the Honorable John G. Koeltl held that the plaintiffs' unjust-enrichment claim was not expressly preempted under FEHBA or the Employee Retirement Income Security Act of 1974, whose preemption clause also "use[s] the phrase 'relate to,'" because the claim did not reference a plan and did not have an impermissible connection to a plan, but rather "would 'merely increase costs'" if successful. 749 F. Supp. 3d at 470-72 (quoting *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 88 (2020)). Plaintiffs make no such argument here. Indeed, they make no effort to argue that, absent a categorical rule against generally applicable laws, their claims are nevertheless unrelated to health insurance or plans.

IV. Conclusion

For the above reasons, the Court grants Anthem's motion to dismiss Plaintiffs' claims with prejudice. The Clerk of Court is respectfully directed to enter judgment in Anthem's favor and to close this case.

SO ORDERED.

Dated: March 2, 2026
New York, New York

JOHN P. CRONAN
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

JANE DOE, on behalf of Baby Doe, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated,

Plaintiffs,

-against-

24 **CIVIL** 8012 (JPC)

JUDGMENT

ANTHEM HEALTHCHOICE ASSURANCE, INC., doing business as Anthem Blue Cross and Blue Shield and Anthem Blue Cross,

Defendants.

----------X

It is hereby **ORDERED, ADJUDGED AND DECREED:** That for the reasons stated in the Court's Opinion and Order dated March 2, 2026, the Court has granted Anthem's motion to dismiss Plaintiffs' claims with prejudice; accordingly, the case is closed.

Dated: New York, New York

March 5, 2026

TAMMI M. HELLWIG

Clerk of Court

BY: K. Mango

Deputy Clerk

JA-149

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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

PLEASE TAKE NOTICE that Plaintiffs Jane Doe, on behalf of Baby Doe, and Patricia Cavallaro-Kearins, on behalf of themselves and all others similarly situated, hereby appeal to the United States Court of Appeals for the Second Circuit from the March 5, 2026 judgment dismissing with prejudice Plaintiffs' Complaint.

Dated: New York, NY
March 31, 2026

Respectfully submitted,

WALDEN MACHT HARAN & WILLIAMS LLP

By: /s/ *Jacob Gardener*

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

POLLOCK COHEN LLP

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

Attorneys for Plaintiffs