ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

In the Matter of

Assurance No. 26-008

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

Carelon Behavioral Health, Inc.,

Respondent.

ASSURANCE OF DISCONTINUANCE

The Office of the Attorney General of the State of New York ("OAG") commenced an investigation pursuant to New York Executive Law § 63(12) into the business practices of Carelon Behavioral Health, Inc. ("Respondent" or "Carelon"). OAG's investigation concerns Respondent's compliance with New York laws governing medical necessity reviews for substance use disorder ("SUD") treatment coverage and with an Assurance of Discontinuance executed in 2015 between OAG and Value Options, Inc., which later merged into Beacon Health Options, Inc. (n/k/a Carelon) ("2015 AOD"). This Assurance of Discontinuance ("Assurance") contains the findings of OAG's investigation and the relief agreed to by OAG and Respondent (collectively, the "Parties"), whether acting through their respective directors, officers, employees, representatives, agents, delegated entities, affiliates, or subsidiaries.

FINDINGS

1. Carelon is a managed behavioral health organization ("MBHO") that has operated in New York State for approximately 20 years and currently administers behavioral health benefits for approximately 4 million New Yorkers, including members of health plans offered by EmblemHealth, Inc. ("Emblem"), Anthem Blue Cross Blue Shield ("Anthem," formerly known

as Empire Blue Cross Blue Shield), Independent Health, and the Empire Plan, which is the health benefit plan for New York State and local governmental employees. Carelon previously administered behavioral health benefits for MVP Health Plan, Inc.

2. Respondent is licensed under New York Insurance Law § 2101 as an Independent Adjuster by the New York State Department of Financial Services ("DFS"). Respondent is also licensed as a Utilization Review Agent by the New York Department of Health ("DOH"), and files utilization review reports with DFS. Carelon's principal offices are located in Boston, Massachusetts.

3. In 2015, after a multiyear investigation in which OAG found, among other things, that Carelon issued many improper denials of claims and requests for SUD treatment coverage, OAG and Carelon executed the 2015 AOD, which required Respondent to overhaul its utilization review practices. The 2015 AOD remains in effect and requires Carelon to, as relevant here: (a) use criteria for substance use disorder medical necessity determinations that have been approved by the New York State Office of Addiction Services and Supports ("OASAS"); and (b) comply with specific utilization review protocols.

4. The opioid epidemic that gave rise to the investigation resolved by the 2015 AOD continues in New York State. In 2022 and 2023, almost 2.8 million New Yorkers 18 and older had a substance use disorder, but only 28.6% received treatment.[1] From 2020 through 2024, 29,358 New Yorkers died from drug overdose deaths.[2]

5. When MBHOs issue coverage denials, health plan members may not receive

[1] National Survey on Drug Use and Health, Table 75B: Substance Use Disorder, Substance Use Treatment, and Mental Health Measures: Among People Aged 12 or Older in New York; by Age Group, Annual Average Numbers (in Thousands), 2022 and 2023, https://www.samhsa.gov/data/sites/default/files/reports/rpt56188/2023-nsduh-sae-state-tables_0/2023-nsduh-sae-state-tabs-new-york.pdf.
[2] New York State Department of Health, Substance Use In NY State: Streamlined Set Of Key Tracking Indicators (May 19, 2025), https://www.health.ny.gov/statistics/opioid/docs/summary_key_drug_indicators.pdf.

medically necessary SUD treatment.

6. In 2023, OAG began an investigation of Carelon relating to its denials of coverage for SUD treatment, in particular its:

a. use of medical necessity criteria not approved by OASAS for medical necessity determinations of claims and requests for coverage of SUD treatment in New York; and

b. denials that do not comply with the requirements of the 2015 AOD, the New York Insurance Law, and the New York Public Health Law.

Respondent's Use of SUD Medical Necessity Criteria Not Approved by OASAS

7. Utilization review is the process by which a Utilization Review Agent such as Carelon evaluates plan members' requests or claims for coverage of health care services to determine whether the services are medically necessary, and thus eligible for coverage. Utilization Review Agents such as Carelon use medical necessity criteria to determine whether services are medically necessary.

8. Documents and information produced by Respondent confirm that it used medical necessity criteria not approved by New York State for substance use disorder coverage determinations in 41 instances out of approximately 7,900 denials between 2015 and 2022. Respondent admitted 21 of these instances. Each instance constitutes a violation of New York law and the 2015 AOD.

Respondent's Improper SUD Treatment Coverage Denials

9. The Level of Care for Alcohol and Drug Treatment Referral ("LOCADTR") is the medical necessity criteria for SUD approved by New York State. LOCADTR requires a full assessment of the patient, which should include at a minimum: presenting problem and history,

current substance use and history of use, diagnostic impressions, current medical history and symptoms, past medical history, mental health screening, current and past mental health symptoms, legal factors, employment, family/social factors, and housing.

10. Paragraph 62(c) of the 2015 AOD requires Respondent to "consult the member's entire case file before rendering any utilization review decision."

11. Paragraph 62(e) of the 2015 AOD requires Respondent to "follow a protocol for the collection of information during utilization review[.]" The protocol requires Respondent to:

a. "Attempt to obtain from members and providers all information necessary for determining whether a request for coverage of treatment meets the medical necessity for the particular level of care at issue. Such information will, at a minimum, include: diagnosis; symptoms; treatment goals; and, where appropriate, risks to the member from not continuing treatment." 2015 AOD, Exhibit A, Paragraph 1.

b. "Inform the provider, and member (where practicable), orally and in writing, of the specific information needed for making the medical necessity determination, the time frame to provide the information, and acceptable methods of submission." 2015 AOD, Exhibit A, Paragraph 2.

c. "In a case in which [it] determines that it lacks sufficient information to make a medical necessity determination, [it] will make reasonable efforts to obtain such information from the member and/or provider within the applicable statutory time frames for rendering decisions, including at least one attempt in writing and at least one attempt telephonically." 2015 AOD, Exhibit A, Paragraph 4.

d. "[N]ot apply any 'fail first' requirement for substance abuse rehabilitation treatment. 2015 AOD, Paragraph 62(f).

e. "[N]ot require that members pose a potential risk of serious harm to self or others in order to satisfy the medical necessity criteria for behavioral health residential treatment or inpatient substance abuse rehabilitation treatment. 2015 AOD, Paragraph 62(g).

12. OAG's review of dozens of case files in which independent external appeal reviewers overturned Respondent's medical necessity denials of SUD treatment revealed a pattern of deficiencies in Respondent's medical necessity review process, as reflected in nine cases. These deficiencies fall into three areas:

a. failure to give adequate consideration to the duration and extent of members' past substance abuse history;

b. failure to meaningfully consider co-occurring psychiatric disorders and obtain sufficient information about them; and

c. minimization of the severity of members' withdrawal symptoms when considering inpatient detoxification treatment.

13. Respondent's deficiencies in its utilization review process led to its denials of coverage in certain cases.

14. OAG's review of case files revealed that Respondent failed to comply with the requirements of the 2015 AOD described in Paragraphs 10 and 11 above.

15. OAG's findings are reinforced by Respondent's high rate of external appeal reversals of its SUD coverage denials from 2019 through 2022: 71% for Empire Plan (17 of 24 denials overturned), 54% for Emblem (27 of 50 denials overturned), and 67% for MVP (4 of 6

denials overturned).[3] Consumers file external appeals in a low percentage of eligible cases.

LEGAL REQUIREMENTS

16. New York State Executive Law § 63(12) authorizes the Attorney General, where there are "repeated fraudulent or illegal acts" or "persistent fraud or illegality in the carrying on, conducting or transaction of business," to seek relief, including enjoining the continuance of such business activity or of any fraudulent or illegal acts, as well as restitution and damages.

17. Since January 1, 2017, New York has required utilization review agents such as Respondent to use only medical necessity criteria approved by OASAS when conducting utilization review for SUD treatment in New York state. N.Y. Ins. Law § 4902(a)(9); N.Y. Pub. Health L. § 4902(1)(i). OASAS designated LOCADTR[4], a tool it developed, as the utilization review criteria for in-state SUD treatment. Respondent acknowledges these requirements.

18. The 2015 AOD requires Carelon to "[e]xercise best efforts to secure approval from OASAS for approval of its criteria for determining medical necessity for SUD treatment."[5] Carelon never received approval for criteria other than LOCADTR for utilization review of in-state SUD treatment.

19. New York Insurance Law §§ 3216(i)(30)(D), 3221(l)(6)(D), and 4303(k)(4) mandate that for in-state inpatient detoxification, rehabilitation, and residential SUD treatment, a medical necessity denial may be issued only if the treatment was contrary to the review tool designated by OASAS.

20. New York Insurance Law §§ 3216(i)(31)(E), 3221(l)(7)(E), and 4303(l)(5) mandate that for in-state outpatient SUD treatment, a medical necessity denial may be issued

[3] Some external appeals were reversed by Carelon before adjudication by external reviewers.
[4] Level of Care for Alcohol and Drug Treatment Referral, https://oasas.ny.gov/locadtr.
[5] 2015 AOD, ¶ 62(g).

only if the treatment was contrary to the review tool designated by OASAS.

21. New York Insurance Law § 2601(a) prohibits unfair claim settlement practices, including, but not limited to, knowingly misrepresenting to claimants pertinent facts relating to coverage.

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

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

24. OAG finds that Respondent's actions and omissions are in violation of: New York Executive Law § 63(12); New York Insurance Law §§ 4902(a)(9), 3216(i)(30)(D), 3221(l)(6)(D), 4303(k)(4), 3216(i)(31)(E), 3221(l)(7)(E), 4303(l)(5); 2601(a), and 4226; New York Public Health L. § 4902(1)(i); and General Business Law §§ 349(a).

25. OAG finds that Respondent violated provisions of the 2015 AOD. Pursuant to New York Executive Law § 63(15), those violations constitute prima facie violations of applicable law.

26. Respondent neither admits nor denies OAG's Findings, Paragraphs 1 through 15 and 24 through 25 above.

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

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

Entities Bound By Assurance

28. This Assurance binds Carelon Behavioral Health, Inc. as well as its principals, officers, successors, and assigns.

Compliance with the Law

29. Respondent shall not engage, or attempt to engage, in conduct in violation of any applicable laws and regulations, including but not limited to those set forth in Paragraph 24 above, and expressly agree and acknowledge that any such conduct is a violation of the Assurance, and that OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 27, in addition to any other appropriate investigation, action, or proceeding.

PROSPECTIVE RELIEF

30. Respondent will begin to implement the relief described in Paragraphs 31 through 35 below immediately upon the full execution of this Assurance.

31. ***SUD Medical Necessity Criteria Policy***. Within thirty (30) days of the Effective Date, Respondent shall submit to OAG for approval a written policy requiring use of only LOCADTR, the OASAS-approved medical necessity criteria, for utilization review of requests and claims for SUD treatment in New York ("SUD Medical Necessity Criteria Policy"). Respondent shall implement the SUD Medical Necessity Criteria Policy within the later of (i) thirty (30) days after OAG approval and (ii) if the SUD Medical Necessity Criteria Policy requires approval from another regulatory agency, within thirty (30) days after approval by such regulatory agency. Carelon shall expeditiously seek any such required approvals.

32. ***SUD Utilization Review Policy***. Within thirty (30) days of the Effective Date, Respondent shall submit to OAG for approval a written policy containing the SUD utilization

review protocols set forth in this Paragraph ("SUD Utilization Review Policy"). Respondent shall implement the SUD Utilization Review Policy within the later of (i) thirty (30) days after OAG approval and (ii) if the SUD Utilization Review Policy requires approval from another regulatory agency, within thirty (30) days after approval by such regulatory agency. Carelon shall expeditiously seek any such required approvals. Under the SUD Utilization Review Policy, Respondent shall:

a. Issue medical necessity denials for SUD treatment in New York State only if such treatment is contrary to LOCADTR.

b. Prior to rendering any utilization review decision, consult the member's entire case file.

c. Attempt to obtain from members (where practicable) or providers all information necessary for determining whether a request for coverage of treatment meets the medical necessity for the particular level of care at issue. Such information will, at a minimum, include: diagnosis; symptoms; treatment goals; and, where appropriate, risks to the member from not continuing treatment.

d. In a case in which it determines that it lacks sufficient information to make a medical necessity determination, make reasonable efforts to obtain such information from the provider within the applicable statutory time frames for rendering decisions, including at least one attempt in writing and at least one attempt telephonically. Except in cases where the member or their designee is inpatient or otherwise not reachable by mail or telephonically, if unable to obtain information sufficient to make a medical necessity determination from the provider, make reasonable efforts to notify the member, including at least one

attempt in writing and at least one attempt telephonically, that the provider has not provided information sufficient to make a medical necessity determination.

e. Inform the provider, and member or their designee (where unable to obtain from the provider), orally and in writing, of the specific information needed for making the medical necessity determination, the time frame to provide the information, and acceptable methods of submission.

f. Not apply any "fail first" requirement for substance abuse rehabilitation treatment.

g. Not require that members pose a potential risk of serious harm to self or others in order to satisfy the medical necessity criteria for SUD treatment.

h. Give adequate consideration to the duration and extent of members' past substance abuse history.

i. Meaningfully consider co-occurring psychiatric disorders and obtain sufficient information about them.

j. Not minimize the severity of members' withdrawal symptoms when considering inpatient detoxification treatment.

33. ***Training***. Respondent shall develop a written training protocol to ensure compliance with the provisions in Paragraphs 31 and 32 above for all personnel involved in Respondent's utilization review processes ("Relevant Personnel"), regardless of whether they are employed by Respondent or third parties, or are independent contractors. Respondent shall submit a written training protocol to OAG within the later of thirty (30) days of OAG approval of the written policies and procedures described in Paragraphs 31 and 32, and (ii) if the written policies and procedures described in Paragraphs 31 and 32 require approval from another regulatory agency, within thirty (30) days after approval by such regulatory agency. Carelon

shall expeditiously seek any such required approvals.

a. Respondent shall train all Relevant Personnel based on the written materials. All Relevant Personnel shall be trained on the materials within the later of (i) thirty (30) days of OAG approval of such materials or (ii) thirty (30) days after approval by any other regulatory agency, if required. Carelon shall expeditiously seek any such required approvals. Thereafter, new Relevant Personnel will be trained within thirty (30) days of commencing their duties.

b. Respondent shall create and maintain records regarding all training conducted pursuant to this Paragraph, including records of attendance. Such records shall be provided to OAG no more than fourteen (14) days after a demand for such records is made.

34. Respondent shall provide OAG with a written report detailing its compliance with the requirements set forth in Paragraphs 31 through 33, to be submitted to OAG within sixty (60) days of OAG approval of the training materials described in Paragraph 33.

RESTITUTION

35. For the period beginning January 1, 2020 through the Effective Date (the "Restitution Period"), Respondent shall provide restitution to all Members whom Respondents determine, based on a review of its records and information provided by Members, falls fall into one or more of the following categories ("Eligible Members"):

a. Made out-of-pocket payments or have unpaid bills for SUD treatment after receiving a denial from Carelon due to application of medical necessity criteria not approved by OASAS.

b. Made out-of-pocket payments or have unpaid bills for SUD treatment after

receiving a medical necessity denial from Carelon due to non-compliance with the provisions set forth in Paragraphs 9 through 14 above.

36. Within thirty (30) days of the Effective Date, Respondent shall provide written notice to Members it has identified who may have received denials for coverage of SUD treatment due to Carelon's (i) application of medical necessity criteria not approved by OASAS or (ii) non-compliance with the provisions set forth in Paragraphs 9 through 14 above ("Potentially Eligible Members"), that they may be eligible for restitution. In the notice Carelon shall ask such Potentially Eligible Members if they incurred out of pocket expenses or have unpaid bills for SUD treatment they received after Carelon issued such denials, and if so, to provide documentation of such expenses or bills. Potentially Eligible Members shall have sixty (60) days after receipt of Carelon's written notice to provide such documentation to Carelon.

37. Respondent shall review claims, utilization review materials (e.g., available medical records, letters of medical necessity, and LOCADTR reports), and other data, including information provided by Potentially Eligible Members, to identify all Eligible Members within one hundred-fifty (150) days of the Effective Date.

38. Within one hundred-eighty (180) days after the Effective Date, Respondent shall issue a restitution payment to each Eligible Member.

39. Within sixty (60) days from the date all restitution payments are made pursuant to Paragraph 38, Respondent shall submit to OAG a restitution report that includes, for each payment: an identifier for the Eligible Member; the date of denial; the type of SUD treatment received or sought; the restitution amount with an explanation as to how it was calculated; and the date on which restitution was issued.

GENERAL PROVISIONS

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

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

42. Respondent expressly agrees and acknowledges that a default in the performance of any obligation under this Assurance is a violation of the Assurance against the defaulting Respondent, and that OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 27, in addition to any other appropriate investigation, action, or proceeding, and that evidence that the Assurance has been violated shall constitute prima facie proof of the statutory violations described in Paragraph 24, pursuant to Executive Law § 63(15).

Ongoing Cooperation

43. Respondent agree to cooperates with all ongoing requests by OAG for information related to this investigation and to ensure compliance with this Assurance.

Penalties, Fees, Costs

44. Respondent shall pay to the State of New York $350,000 in penalties, fees, and costs. Payment shall be made in full by wire transfer within thirty (30) business days of the

Effective Date of this Assurance. OAG shall provide transfer information to Respondent.

45. The Parties agree that it would be difficult to value the damages caused by default in the performance of any obligation under this Paragraph, and therefore agree that Respondent shall pay to the State of New York a stipulated penalty of $20,000 for each and every such material default in the performance of any obligation under this Paragraph occurring after the effective date of the Assurance.

Subsequent Proceedings

46. Respondent expressly agrees and acknowledges that OAG may initiate a subsequent investigation, civil action, or proceeding to enforce this Assurance, for violations of the Assurance, or if the Assurance is voided pursuant to Paragraph 51, and agree and acknowledge that in such event:

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

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

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

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

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

and court costs.

Effects of Assurance

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

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

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

Communications

51. All notices, reports, requests, and other communications pursuant to this Assurance must reference Assurance No. 26-008, and shall be in writing and shall, unless expressly provided otherwise herein, be given by hand delivery; express courier; or electronic mail at an address designated in writing by the recipient, followed by postage prepaid mail, and shall be addressed as follows:

> If to Respondent, to: Kelly Masley, or in their absence, to the person holding the title of Chief Legal Officer.
>
> If to OAG, to: Michael D. Reisman, or in his absence, to the person holding the title of Bureau Chief, Health Care Bureau.

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

Representations and Warranties

52. OAG has agreed to the terms of this Assurance based on, among other things, the representations made to OAG by Respondent and its counsel and OAG's own factual investigation as set forth in Findings, Paragraphs 1 through 15 above. Respondent represents and warrant that neither they nor their counsel have made any material representations to OAG that are inaccurate or misleading. If any material representations by Respondent or its counsel are later found to be inaccurate or misleading, this Assurance is voidable by OAG in its sole discretion.

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

54. Respondent represents and warrants, through the signatures below, that the terms and conditions of this Assurance are duly approved. Respondent further represents and warrants that Carelon Behavioral Health, Inc., by Dr. Patrick Fox, as the signatory to this Assurance, is a duly authorized officer acting at the direction of the Board of Directors of Carelon Behavioral Health, Inc.

General Principles

55. Unless a term limit for compliance is otherwise specified within this Assurance, Respondent's obligations under this Assurance are enduring.

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

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

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

59. Nothing contained herein shall be construed to limit the remedies available to OAG in the event that Respondent violates the Assurance after its effective date.

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

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

62. Respondent acknowledges that it has entered this Assurance freely and voluntarily and upon due deliberation with the advice of counsel.

63. This Assurance shall be governed by the laws of the State of New York without

regard to any conflict of laws principles. The Assurance and all its terms shall be construed as if mutually drafted with no presumption of any type against any party that may be found to have been the drafter.

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

65. The Effective Date of this Assurance shall be November 10, 2026.

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

By: _____
Michael D. Reisman
Assistant Attorney General
Health Care Bureau

Carelon Behavioral Health, Inc.

By: _____
Dr. Patrick Fox
President