

Nos. 20-17363, 20-17364, 21-15193, 21-15194

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID AND NATASHA WIT, et al.,
Plaintiffs-Appellees,

vs.

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, et al.,
Plaintiffs-Appellees,

vs.

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

On Appeal from the United States District Court
for the Northern District of California
Nos. 14-cv-2346-JCS, 14-cv-5337-JCS | Hon. Joseph C. Spero

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TABLE OF CONTENTS

	Page
Table of Authorities.....	iii
Introduction.....	1
Jurisdictional Statement.....	3
Statement of the Issues.....	3
Statement of the Case	4
A. UBH’s Fiduciary Duties.....	4
B. The Certified Classes and their ERISA Claims	5
C. Pertinent Factual Findings.....	7
1. The Plans’ Generally-Accepted-Standards Requirement.....	7
2. UBH’s Creation and Application of its Guidelines in Place of Generally Accepted Standards.	8
3. UBH’s Conflict of Interest in Developing its Guidelines	10
4. UBH’s Guidelines Are More Restrictive than Generally Accepted Standards	13
5. UBH’s Denial of Class Members’ Requests for Coverage Based on its Guidelines	16
D. UBH’s Liability for Violating its ERISA Duties.....	17
E. Remedies for UBH’s ERISA Violations	18
Summary of the Argument	19
Standard of Review	25
Argument.....	26

I.	UBH’s Denials of Coverage Injured Class Members and Gave Rise to ERISA Claims.	26
A.	An ERISA Plan Member Has Article III Standing to Challenge the Denial of a Request for Coverage Based on UBH’s Invalid Guidelines, Regardless of Monetary Loss.....	27
B.	An ERISA Plan Member has Claims for Equitable Relief under 29 U.S.C. § 1132(a) to Redress the Denial of a Request for Coverage Based on UBH’s Invalid Guidelines.....	44
C.	The District Court Did Not Violate the Rules Enabling Act by Certifying Classes Whose Members All Had Article III Standing and Common ERISA Claims.	51
II.	The District Court Properly Applied the Abuse of Discretion Standard.....	55
A.	The District Court Did Not Rewrite Any Plans or Require Coverage of All Services that Comply with Generally Accepted Standards of Care.....	55
B.	The “Substantial Evidence” Standard Did Not Apply to the District Court’s Review of UBH’s Guidelines.	56
C.	The District Court’s Skepticism Was Justified by its Factual Findings that UBH’s Self-Interest Actually Tainted the Guidelines UBH Applied to All Plans.	60
III.	Courts Excuse Exhaustion of ERISA Plan Contractual Remedies When It Would Be Futile.	61
	Conclusion	71
	Certificate of Compliance.....	73
	Certificate of Service	74
	Addendum	1a

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Abatie v. Alta Health & Life Ins. Co.</i> , 458 F.3d 955 (9th Cir. 2006)	58
<i>Aberdeen Ry. Co. v. Blaikie Bros.</i> , (1854) 2 L.R. Eq. 1281 (H.L.)	37
<i>Aetna Life Ins. Co. v. Haworth</i> , 300 U.S. 227 (1937)	34
<i>Allied Pros. Ins. Co. v. Anglesey</i> , 680 F. App'x 586 (9th Cir. 2017)	34
<i>Almont Ambulatory Surgery Center, LLC v. UnitedHealth Group</i> , No. CV-14-02139-MWF, 2016 WL 6601662 (C.D. Cal. Feb. 3, 2016)	46
<i>Amaro v. Cont'l Can Co.</i> , 724 F.2d 747 (9th Cir. 1984)	69
<i>Amato v. Bernard</i> , 618 F.2d 559 (9th Cir. 1980)	62, 63, 64, 66
<i>Anderson v. Intel Corp.</i> , No. 19-CV-04618-LHK, 2021 WL 229235 (N.D. Cal. Jan. 21, 2021)	40, 41
<i>Art Attacks Ink, LLC v. MGA Ent. Inc.</i> , 581 F.3d 1138 (9th Cir. 2009)	56
<i>Ballas v. Anthem Blue Cross Life & Health Ins. Co.</i> , No. CV 12-00604 MMM (FFMx), 2013 WL 12119569 (C.D. Cal. Apr. 29, 2013)	53
<i>Barnes v. AT&T Pension Ben. Plan-Nonbargained Program</i> , 270 F.R.D. 488 (N.D. Cal. 2010)	67

Blau v. Del Monte Corp.,
748 F.2d 1348 (9th Cir. 1984) 30

Bowen v. City of New York,
476 U.S. 467 (1986) 65

Carney v. Adams,
141 S. Ct. 493 (2020) 34, 35

Castillo v. Metro. Life Ins. Co.,
970 F.3d 1224 (9th Cir. 2020) 7

Chorosevic v. MetLife Choices,
No. 4:05-CV-2394 CAS, 2009 WL 723357 (E.D. Mo. Mar. 17,
2009) 46

Churchill v. Cigna Corp.,
Civ. No. 10-6911, 2011 WL 3563489 (E.D. Pa. Aug. 12, 2011)..... 68

CIGNA Corp. v. Amara,
563 U.S. 421 (2011) 46, 47

Coffin v. Bowater Inc.,
228 F.R.D. 397 (D. Me. 2005)..... 68

Conservation Force, Inc. v. Manning,
301 F.3d 985 (9th Cir. 2002) 35

Counts v. Am. Gen. Life & Acc. Ins. Co.,
111 F.3d 105 (11th Cir. 1997) 64

Craddock v. Greenhut Constr. Co., Inc.,
423 F.2d 111 (5th Cir. 1970) 65

Davoue v. Fanning,
2 Johns. Ch. 252 (N.Y. Ch. 1816) 37

Dennis F. v. Aetna Life Insurance,
No. 12-CV-02819-SC, 2013 WL 5377144 (N.D. Cal. Sept. 25,
2013) 52

Des Roches v. Cal. Physicians’ Serv.,
320 F.R.D. 486 (N.D. Cal. 2017) 52

Diaz v. United Agric. Emp. Welfare Benefit Plan,
50 F.3d 1478 (9th Cir. 1995) 67, 70

Doe v. Chao,
540 U.S. 614 (2004) 33

Dorman v. Charles Schwab Corp.,
934 F.3d 1107 (9th Cir. 2019) 69

Fallick v. Nationwide Mut. Ins. Co.,
162 F.3d 410 (6th Cir. 1998) 62

Fed. Election Comm’n v. Akins,
524 U.S. 11 (1998) 38

Fujikawa v. Gushiken,
823 F.2d 1341 (9th Cir. 1987) 69

Glover v. St. Louis-S.F. Ry. Co.,
393 U.S. 324 (1969) 66

Gov’t Emps. Ins. Co. v. Dizol,
133 F.3d 1220 (9th Cir. 1998) 34

Graddy v. BlueCross BlueShield of Tennessee, Inc.,
No. 4:09-cv-84, 2010 WL 670081 (E.D. Tenn. Feb. 19, 2010)..... 53

Harlick v. Blue Shield of Cal.,
686 F.3d 699 (9th Cir. 2012) 42

Hitchcock v. Cumberland Univ. 403(b) Plan DC Plan,
851 F.3d 552 (6th Cir. 2017) 62

Huntsinger v. Shaw Group, Inc.,
268 F. App’x 518 (9th Cir. 2008) 48

In re Household Int’l Tax Reduction Plan,
441 F.3d 500 (7th Cir. 2006) 67

Jackson v. Smith,
254 U.S. 586 (1921) 37

Jones v. United Behavioral Health,
No. 19-cv-06999-RS, 2021 WL 1318679 (N.D. Cal. Mar. 11, 2021)..... 52

Keech v. Sandford,
(1726) 25 Eng. Rep. 223 (Ch.) 36

L.K. Comstock & Co. v. United Eng’rs & Constructors Inc.,
880 F.2d 219 (9th Cir. 1989) 65

Laurenzano v. Blue Cross & Blue Shield of Mass., Inc. Ret. Income Tr., 134 F. Supp. 2d 189 (D. Mass. 2001)..... 67

Leon v. Standard Ins. Co.,
No. 2:15-cv-07419-ODW(JC), 2016 WL 768908 (C.D. Cal. Jan. 28, 2016) 67

Lexmark International, Inc. v. Static Control Components, Inc.,
572 U.S. 118 (2014) 48

LSO, Ltd. v. Stroh,
205 F.3d 1146 (9th Cir. 2000) 35

Magruder v. Drury,
235 U.S. 106 (1914) 37

Maryland Cas. Co. v. Pac. Coal & Oil Co.,
312 U.S. 270 (1941) 34

McBride Cotton & Cattle Corp. v. Veneman,
290 F.3d 973 (9th Cir. 2002) 65

Metro. Life Ins. Co. v. Glenn,
554 U.S. 105 (2008) 60

Michoud v. Girod,
45 U.S. (4 How.) 503 (1846) 37

Nayab v. Capital One Bank (USA), N.A.,
942 F.3d 480 (9th Cir. 2019) 31

Noren v. Jefferson Pilot Fin. Ins. Co.,
378 F. App'x 696 (9th Cir. 2010) 64

Pannebecker v. Liberty Life Assur. Co. of Bos.,
542 F.3d 1213 (9th Cir. 2008) 30, 50

Parish v. Legion,
450 F.2d 821 (9th Cir. 1971) 66

Parsons v. Ryan,
754 F.3d 657 (9th Cir. 2014) 53

Pecere v. Empire Blue Cross & Blue Shield,
194 F.R.D. 66 (E.D.N.Y. 2000) 53

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 34, 46

Plumber, Steamfitter & Shipfitter Indus. Pension Plan & Tr. v. Siemens Bldg. Techs. Inc.,
228 F.3d 964 (9th Cir. 2000) 25

Pub. Citizen v. U.S. Dep't of Just.,
491 U.S. 440 (1989) 38

Ramirez v. TransUnion LLC,
951 F.3d 1008 (9th Cir. 2020) 32

Robins v. Spokeo, Inc.,
867 F.3d 1108 (9th Cir. 2017) 31, 32, 33

Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan,
85 F.3d 455 (9th Cir. 1996) 25, 43, 47, 50

Schmookler v. Empire Blue Cross & Blue Shield,
107 F.3d 4 (2d Cir. 1997)..... 68

Snow v. Standard Insurance Co.,
87 F.3d 327 (9th Cir. 1996) 58

Southcentral Foundation v. Alaska Native Tribal Health Consortium,
983 F.3d 411 (9th Cir. 2020) 39

Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.,
770 F.3d 1282 (9th Cir. 2014) 69, 70

Spokeo v. Robins,
136 S. Ct. 1540 (2016) 28, 29, 31, 36, 39

Stephens v. Pension Ben. Guar. Corp.,
755 F.3d 959 (D.C. Cir. 2014)..... 69

Stephens v. U.S. Airways Grp., Inc.,
No. 07-cv-1264 (RMC), 2012 WL 13054263
(D.D.C. July 18, 2012) 68

Thole v. U.S. Bank, N.A.,
140 S. Ct. 1615 (2020) 39, 40, 41

Thomas v. SmithKline Beecham Corp.,
201 F.R.D. 386 (E.D. Pa. 2001) 67

Trinity Lutheran Church of Columbia, Inc. v. Comer,
137 S. Ct. 2012 (2017) 35

United States v. Carter,
217 U.S. 286 (1910) 37

Varsity Corp. v. Howe,
516 U.S. 489 (1996) 46

Vizcaino v. Microsoft Corp.,
120 F.3d 1006 (9th Cir. 1997) 48, 49

Vt. Agency of Nat. Res. v. U.S. ex rel. Stevens,
529 U.S. 765 (2000) 36

Wal-Mart Stores, Inc. v. Dukes,
564 U.S. 338 (2011) 53

Whelpdale v. Cookson,
 (1747) 27 Eng. Rep. 856 (Ch.) 37

Williams v. Pac. Mar. Ass’n,
 617 F.2d 1321 (9th Cir. 1980) 69

Wolff & Munier, Inc. v. Whiting-Turner Contracting Co.,
 946 F.2d 1003 (2d Cir. 1991) 65

Z.D. ex rel. J.D. v. Grp. Health Co-op.,
 No. C11-1119RSL, 2012 WL 5033422 (W.D. Wash. Oct. 17, 2012) 47

Statutes

28 U.S.C. § 1291 3

28 U.S.C. § 1292(a) 3

28 U.S.C. § 1331 3

29 U.S.C. § 1001(a) 29, 32

29 U.S.C. § 1001(b) 2, 29, 30

29 U.S.C. § 1002(14)(A) 4

29 U.S.C. § 1002(21)(A) 4

29 U.S.C. § 1021(a) 37

29 U.S.C. § 1022 37

29 U.S.C. § 1024(b) 37

29 U.S.C. § 1104(a)(1) 4, 30, 32

29 U.S.C. § 1132 46

29 U.S.C. § 1132(a) 30

29 U.S.C. § 1132(a)(1)(B) 2, 7, 18, 20, 34, 46

29 U.S.C. § 1132(a)(3) 2, 7, 18, 20, 46

29 U.S.C. § 1132(e)(1)..... 3

29 U.S.C. § 1133(1)..... 17

29 U.S.C. § 1133(a)..... 37

29 U.S.C. § 1185a 35

42 U.S.C. § 18116(a) 35

42 U.S.C. § 405(g) 58

5 U.S.C. § 552a(g)(1)(A)..... 33

5 U.S.C. § 556 57

5 U.S.C. § 557 57

5 U.S.C. § 706(2)(E) 57

Other Authorities

3 Austin Wakeman Scott et al., *Scott and Ascher on Trusts* § 17.2
 (5th ed. 2007)..... 36

Bogert’s *Law of Trusts & Trustees* § 862..... 36

Restatement (Third) of *Trusts* § 78(1) 36

Rules

Fed. R. Civ. P. 23..... 51

Fed. R. Civ. P. 23(a)..... 51

Fed. R. Civ. P. 23(b)..... 6, 51, 52, 53

Fed. R. Civ. P. 23(f) 51

Regulations

29 C.F.R. § 2560.503-1 17, 28, 37, 71

Constitutional Provision

U.S. Const., Art. III *passim*

INTRODUCTION

After a ten-day trial, the District Court found that United Behavioral Health (“UBH”) breached its fiduciary duties and wrongfully denied the class members’ requests for coverage in violation of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (“ERISA”). In its remedial order, the District Court summarized its comprehensive findings of fact:

UBH denied mental health and substance use disorder treatment coverage to tens of thousands of class members using internal guidelines that were inconsistent with the terms of the class members’ health insurance plans. UBH engaged in this course of conduct deliberately, to protect its bottom line. To conceal its misconduct, UBH lied to state regulators and UBH executives with responsibility for drafting and implementing the guidelines deliberately attempted to mislead the Court at trial in this matter.

[1-ER-92](#) (Remedies Order) (“Remedies”); *see also* [2-ER-230-326](#)

(Findings of Fact and Conclusions of Law) (“FFCL”).

Even UBH’s sole retained expert admitted at trial that UBH’s guidelines were far too restrictive. He testified that no physicians “worth their salt” would use UBH’s guidelines to “make clinical judgments” because of irreconcilable “discrepanc[ies]” between the guidelines and the generally accepted standards of care required by the plan terms. [8-ER-1696:15-1698:1](#).

The District Court’s factual findings, which UBH does not and could not claim are clearly erroneous, conclusively establish for purposes of this appeal that every member of the certified classes was injured for purposes of Article III by UBH’s denial of a request for coverage based on its invalid guidelines. Every member of the certified classes also has an ERISA claim for equitable relief including reprocessing of their claims under the correct standard. [29 U.S.C. § 1132\(a\)\(1\)\(B\)](#) (right to “enforce” or “clarify” rights under the terms of the plan); *id.* [§ 1132\(a\)\(3\)\(A\)](#) (right “to enjoin any act or practice which violates any provision of” ERISA or the plan); *id.* [§ 1132\(a\)\(3\)\(B\)](#) (right “to obtain other appropriate equitable relief” for such violations or to enforce ERISA or plan terms).

UBH’s “pervasive and long-standing violations of ERISA,” [1-ER-92](#) (Remedies), are exactly the kind of misconduct Congress enacted ERISA to prevent and, if necessary, to remedy. [29 U.S.C. § 1001\(b\)](#). UBH denied the class members’ requests for coverage under their plans based on its guidelines—i.e., its unreasonable interpretation of the plans’ generally accepted standards of care requirement. In so doing, UBH breached its fiduciary duties and departed from the plan terms.

The District Court's liability rulings and its judgment redressing those violations on a class-wide basis should be affirmed.

JURISDICTIONAL STATEMENT

The Court has appellate and subject matter jurisdiction pursuant to [28 U.S.C. §§ 1291](#) or [1292\(a\)](#), [28 U.S.C. § 1331](#), and [29 U.S.C. § 1132\(e\)\(1\)](#).

STATEMENT OF THE ISSUES

I. Is the unlawful denial of a request for coverage under an ERISA plan an Article III injury in fact, actionable under ERISA, when each class member was denied a request for coverage of prescribed treatment, Congress expressly authorized judicial redress, a breach of fiduciary duty was historically actionable without monetary loss, and a denial of coverage is closely tied to harm (monetary loss, no treatment, or less effective treatment)?

II. Was the District Court obliged to find facts at trial, such as whether UBH's guidelines complied with generally accepted standards of care and whether UBH's conflict of interest infected its guideline-development process, using a "substantial evidence" standard (rather than a preponderance)?

III. Did the District Court err in excusing absent class members from satisfying their plans' administrative exhaustion requirements on grounds of futility?

STATEMENT OF THE CASE

This is a consolidated appeal from orders and the final judgment of the United States District Court for the Northern District of California (Spero, J., by consent) in two consolidated class actions, *Wit v. United Behavioral Health* and *Alexander v. United Behavioral Health*. The District Court held UBH, a California corporation domiciled in San Francisco, liable for violating ERISA and granted equitable relief to remedy those violations.

A. UBH's Fiduciary Duties

UBH administers mental health and substance use disorder benefits for ERISA plans. [2-ER-328](#) (FFCL). UBH is a fiduciary, [29 U.S.C. §§ 1002\(14\)\(A\) & \(21\)\(A\)](#), and must administer the plans "solely in the interest of the participants and beneficiaries" and "in accordance with the documents and instruments governing the plan." [29 U.S.C. § 1104\(a\)\(1\) & \(a\)\(1\)\(D\)](#); [2-ER-328](#) (FFCL).

B. The Certified Classes and their ERISA Claims

The District Court certified three classes. The members of each class, by definition, requested coverage under their ERISA-governed plans for behavioral health treatment, and UBH denied the requests “based in whole or in part” on its guidelines. [1-ER-213-215](#) (final class definitions); [1-ER-3](#) (Judgment).

“*Wit* Guideline Class” members were denied coverage for residential treatment, and “*Alexander* Guideline Class” members were denied coverage for outpatient or intensive outpatient treatment. [1-ER-213-215](#) (class definitions); [2-ER-236-237](#) (FFCL). The *Wit* case also included a “State Mandate Class,” whose plans were subject to state laws specifying the criteria for making medical necessity determinations. [1-ER-195](#) (Decert. Order); [2-ER-236-237](#) (FFCL).¹

¹ The District Court found that UBH’s use of its guidelines violated those state laws, [2-ER-310-16](#) (FFCL), and that “UBH lied to state regulators” “[t]o conceal its misconduct.” [1-ER-92](#) (Remedies); [2-ER-310-334](#) (FFCL). UBH has not raised any issues specific to the State Mandate Class, thereby conceding that its guidelines did not comport with the state law requirements. This brief, therefore, focuses on the conflict between UBH’s guidelines and generally accepted standards of care.

The District Court certified all three classes under [Federal Rule of Civil Procedure 23\(b\)\(1\)\(A\), \(b\)\(2\), and \(b\)\(3\)](#). [2-ER-335-389](#) (Class Cert. Order). After trial, the court modified the class definitions to exclude members whose requests for coverage, although initially denied, were later approved in full on appeal; to modify the Illinois State Mandate Class period; and to exclude some members because of a flaw in the initial process used to identify class members. [1-ER-213](#) (Decert. Order).

The members of all three classes alleged that UBH violated the terms of their Plans and breached its fiduciary duties by denying their requests for coverage pursuant to its guidelines. [2-ER-238-239](#) (FFCL). The classes sought relief under ERISA's civil enforcement provision, which provides: “[a] civil action may be brought—”

(1) by a participant or beneficiary— * * * **(B)** to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

* * *

(3) by a participant, beneficiary, or fiduciary **(A)** to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or **(B)** to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

[29 U.S.C. §§ 1132\(a\)\(1\)\(B\) & \(a\)\(3\)](#). The classes sought the same relief under both provisions.²

C. Pertinent Factual Findings

After trial, the District Court issued more than 113 pages of meticulously-supported factual findings. [2-ER-229-334](#) (FFCL); Further Findings of Fact and Conclusions of Law, [1-ER-216-222](#) (“Further FFCL”).

1. The Plans’ Generally-Accepted-Standards Requirement

“The terms of the plans of each class member * * * required, as one condition of coverage, that services be consistent with generally accepted standards of care.” [1-ER-3](#) (Judgment); [2-ER-253](#) (FFCL); *accord* [UBH Br. 8](#). UBH developed and applied a standardized set of clinical guidelines to determine whether that requirement was satisfied for *all* commercial plans it administered. [2-ER-247-248](#) (FFCL). The

² “Claims under [§ 1132\(a\)\(1\)\(B\)](#) and [§ 1132\(a\)\(3\)](#) * * * may proceed simultaneously so long as there is no double recovery.” [Castillo v. Metro. Life Ins. Co.](#), 970 F.3d 1224, 1229 (9th Cir. 2020) (cleaned up); [2-ER-332](#) (FFCL). The classes rely on [§ 1132\(a\)\(3\)](#) only to the extent [§ 1132\(a\)\(1\)\(B\)](#) does not provide adequate relief for UBH’s unlawful denials of coverage.

guidelines themselves “are not Plan terms.” [2-ER-253-254](#) (FFCL); *see also* [1-ER-3](#) (Judgment).

2. UBH’s Creation and Application of its Guidelines in Place of Generally Accepted Standards.

To ensure consistent interpretation of the plans’ generally-accepted-standards requirement, UBH developed Level of Care Guidelines (“LOCs”), organized by level of care (e.g., residential, intensive outpatient, or outpatient), and Coverage Determination Guidelines (“CDGs” and together with the LOCs, the “Guidelines”), generally organized by diagnosis. [2-ER-247, 250](#) (FFCL). UBH revised the Guidelines annually; only one version of the LOCs and one version of each CDG were in effect at a time. [2-ER-248-251](#) (FFCL). UBH used the same Guidelines to administer both fully-insured plans (for which it pays the benefits) and self-insured plans (for which the plan sponsor pays benefits when authorized by UBH). [2-ER-250-251, -320](#) (FFCL).

UBH developed its uniform Guidelines internally, without involvement of the sponsors of the plans it administers. [2-ER-316, -253-54](#) (FFCL). Although UBH solicited “feedback from external clinicians and professional societies,” [UBH Br. 12](#), that input was limited to

whether the Guidelines were “easy to use” or if any “criteria * * * should be added or deleted.” [2-ER-317-318](#) (FFCL). UBH did not solicit input from anyone about whether its Guidelines were consistent with generally accepted standards of care. [2-ER-318](#) (FFCL).³

UBH regarded the Guidelines as “objective criteria for making standardized decisions about coverage,” [2-ER-254](#) (FFCL), and required its reviewers to use them when determining whether requested services were consistent with generally accepted standards. [2-ER-247](#) (FFCL); [2-SER-302-303](#) (Trial Exhibit (“TX”) 256-0017-18).

UBH carefully monitored application of its Guidelines for consistency. [2-ER-246-47](#) (FFCL). Its employees’ annual “Inter-Rater Reliability” measures neared 100%, [2-ER-342](#) (FFCL), “reflect[ing] that the guidelines [were] applied consistently.” [2-ER-246](#) (FFCL). The near-perfect consistency ratings, moreover, reflected that UBH’s employees applied the Guidelines as written: “their exercise of clinical judgment is

³ Accreditation “by ‘the two leading [independent] organizations that accredit utilization management processes for major health plans’” concerned only the *process* UBH followed, “not the substantive content of [the] guidelines.” [2-ER-318](#) (FFCL). Compare [UBH Br. 12](#).

constrained by the criteria for coverage set forth in the Guidelines, which are mandatory.” [2-ER-246-247](#) (FFCL).⁴

Under UBH’s standard procedures, a front-line reviewer first decides whether all administrative requirements for coverage are satisfied, including non-clinical plan exclusions, before referring the request to a Peer Reviewer to apply clinical standards using the Guidelines. [2-ER-251](#) (FFCL). Any claim denied pursuant to the Guidelines must therefore have survived UBH’s application of the plan’s non-clinical coverage criteria and exclusions.

3. UBH’s Conflict of Interest in Developing its Guidelines

UBH carefully monitors the cost of benefits (referred to as benefit expense or “benex”), which it has an incentive to minimize—especially for fully-insured plans (to reduce payments from its own funds), but also for self-funded plans (to keep costs down for its customers). [2-ER-319-320](#) (FFCL). [REDACTED]

⁴ Before trial, the parties stipulated that “neither party will offer evidence of the medical or claim review history of any class member, including named plaintiff and the claim sample members.” [1-SER-283](#) (Pre-Trial Conf. Tr.).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] 15-ER-3016 (FFCL).

The District Court further found that UBH’s “financial incentives” “in fact, infected the Guideline development process.” [2-ER-320](#) (FFCL). Employees responsible for UBH’s financial interests participated in that process, and the financial implications of Guideline changes, which “have a direct impact on benefit expense,” actually influenced UBH’s Guideline decisions. [2-ER-320](#) (FFCL); [2-ER-321-25](#) (FFCL).

The District Court found “the record is replete with evidence that UBH’s Guidelines were viewed as an important tool for meeting utilization management targets, ‘mitigating’ the impact of the 2008 Parity Act, and keeping ‘benex’ down.” [2-ER-321](#) (FFCL) (citing, *inter alia*, [2-SER-352](#) (TX 768-0009)).⁵ One particularly “telling” example was

⁵ In 2008, to eliminate insurers’ and plans’ ongoing discrimination against mental health benefits, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the “Parity Act”), [Pub. L. 110-343, § 512\(a\), 122 Stat. 3881, 3892; 78 Fed. Reg. 68239-96 \(2013\)](#) (final rule, effective January 2014). Faced with potential increases in benefit expense, UBH developed Parity-Act

“UBH’s decision *not* to adopt the [American Society of Addiction Medicine (“ASAM”)] Criteria for making substance use disorder coverage determinations.” [2-ER-323](#) (FFCL). “UBH rejected the recommendation of its clinicians with respect to the use of ASAM Criteria because it could not be sure that use of the ASAM Criteria would not increase BenEx.” [2-ER-323-325](#) (FFCL); *see also* [2-ER-331-332](#) (ASAM Criteria example shows “UBH’s Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change * * * that all of its clinicians had recommended.”); [2-SER-311](#) (TX 524-0002); [2-SER-307](#) (TX 348-0002); [2-SER-320](#) (TX 548-0034); [6-ER-1234:7-1235:3](#).

Although UBH’s financial incentives to minimize benefit expense are more direct for fully-insured plans than for self-funded plans, “any resulting shortcomings in its Guideline development process taints [UBH’s] decision-making as to both categories of plan because UBH maintains a uniform set of Guidelines for fully insured and self-funded plans.” [2-ER-320](#) (FFCL). The District Court therefore applied

“mitigation strategies,” including using “robust” guidelines to deny coverage. [2-ER-321](#) (FFCL); [2-SER-344-372](#) (TX 768).

“skepticism” towards UBH’s interpretation of plan terms via the Guidelines for fully-insured and self-funded plans alike. [2-ER-331-332](#) (FFCL).

4. UBH’s Guidelines Are More Restrictive than Generally Accepted Standards

After trial, the District Court made careful, detailed and explicit findings about the credibility of the witnesses as the predicate for its other factual findings. [2-ER-239-246](#) (FFCL). It found UBH’s only retained non-employee expert not credible because his “opinions about the Guidelines were premised on the assumption”—which the court found was wrong, [2-ER-242-243](#) (FFCL)—“that practitioners making medical necessity determinations for UBH are authorized to ignore the plain language of the Guidelines when it is inconsistent with generally accepted standards of care.” *Id.*; see also [8-ER-1636:10-38:13](#); [8-ER-1718:11-22](#). UBH’s retained expert acknowledged that no “practitioner worth his salt” would follow the UBH Guidelines as written in making treatment decisions, but rather would consult source documents for the generally accepted standards of care to “reconcile the discrepancy” between the UBH Guidelines and those standards. [2-ER-242](#) (FFCL).

The District Court found the plans’ generally-accepted-standards requirement referred to “the standards that have achieved widespread acceptance among behavioral health professionals,” [2-ER-255](#) (FFCL), and that eight high-level principles comprised the relevant “generally accepted standards of care that apply to patient placement in the context of behavioral health treatment.” [2-ER-261-70](#) (FFCL). There was virtually no dispute on those principles. *Id.* The parties’ experts also agreed on a set of sources that accurately reflected those generally accepted standards. [2-ER-255-256](#) (FFCL). *See also* [3-ER-521-22](#) (ASAM Criteria); [7-ER-1412](#) (same); [9-ER-1831](#) (same); [10-ER-2112](#) (same); [8-ER-1607](#) (same, and Level of Care Utilization System (“LOCUS”)); [5-ER-955](#) (LOCUS); [9-ER-1909](#) (Child and Adolescent LOCUS (“CALOCUS”)).

The District Court next analyzed in detail UBH’s LOCGs and its Custodial Care CDGs and found, as fact, that those Guidelines were “significantly and pervasively more restrictive than generally accepted standards of care.” [2-ER-270-316](#) (FFCL); *see also* [1-ER-4](#) (Judgment). They: (1) “place[d] excessive emphasis on acuity and crisis stabilization, while ignoring the effective treatment of members’ underlying

conditions”; (2) “fail[ed] to address the effective treatment of co-occurring conditions”; (3) “fail[ed] to err on the side of caution in favor of higher levels of care when there is ambiguity and, instead, push[ed] patients to lower levels of care where such a transition is safe, even if the lower level of care [was] likely to be less effective”; (4) “preclude[d] coverage for treatment to maintain level of function”; (5) “preclude[d] coverage based on lack of motivation”; (6) “fail[ed] to address the unique needs of children and adolescents”; (7) “use[d] an overly broad definition of ‘custodial care,’ coupled with an overly narrow definition of ‘active’ treatment and ‘improvement’”; and (8) “impose[d] mandatory prerequisites for coverage rather than determining the appropriate level of care based on a multidimensional approach.” [1-ER-4-5](#) (Judgment); [2-ER-270-306](#) (FFCL).

The defects were “pervasive” and structural. [2-ER-270](#) (FFCL). They were designed to implement UBH’s “Acute Care Utilization Management Model,” [2-ER-272](#) (FFCL), and “result[ed] in a significantly narrower scope of coverage than is consistent with generally accepted standards of care.” [2-ER-270](#) (FFCL). The LOCGs included mandatory “Common Criteria,” *all* of which had to be met to

qualify for coverage at any level of care, as well as additional requirements for each level of care. [2-ER-249-250](#) (FFCL). The CDGs incorporated the level-of-care criteria from the LOCGs. [1-ER-222](#) (Further FFCL). The Common Criteria, therefore, had to be satisfied for UBH to approve coverage under any plan, for any level of care, whether UBH applied the LOCGs directly or via its CDGs. Because those criteria were “riddled” with errors, the District Court found that every Guideline-based denial *necessarily* implicated one or more of the many defects the District Court found. [2-ER-321](#) (FFCL); [2-ER-249-250](#) (FFCL); [1-ER-218-222](#) (Further FFCL); [1-ER-203](#) (Decert. Order).⁶

5. UBH’s Denial of Class Members’ Requests for Coverage Based on its Guidelines

ERISA requires UBH, if issuing an adverse benefit determination, to provide written notification of the “specific reasons for such denial.”

⁶ The parties’ “Consolidated Claims Chart” identifies each criterion Plaintiffs challenged within each version of the LOCGs and the Custodial Care CDGs—233 distinct provisions. [1-SER-12-266](#). The District Court found that nearly all those requirements ran afoul of generally accepted standards—including multiple mandatory criteria in each edition. [2-ER-270 n.12](#), [-282-3 n.13](#), [-285 n.14](#), [-293](#), [-297 n.16](#) (FFCL). The District Court also found overarching deficiencies that permeated the Guidelines each year. *See, e.g.*, [2-ER-296](#), [-306](#), [-309](#) (FFCL).

[29 U.S.C. § 1133\(1\)](#). *See also* [29 C.F.R. § 2560.503-1\(g\)\(1\)\(i\)-\(ii\)](#)

(requiring notice of “[t]he specific reason or reasons” for denial and “[r]eference to the specific plan provisions on which the determination is based”); [2-ER-252](#) (FFCL) (“As a matter of UBH policy, UBH’s denial letters must summarize *all* the reasons for denial.”). UBH’s citation to the Guidelines in each class member’s denial establishes that each denial was based on the Guidelines in whole or in part. [1-ER-213-215](#) (class definitions); [2-ER-247-248](#), [252](#) (FFCL); [2-SER-403-420](#) (TX 894).

D. UBH’s Liability for Violating its ERISA Duties

Based on its findings that UBH had a structural conflict of interest, which actually tainted the Guideline-development process, and that UBH applied the same Guidelines to fully-insured and self-funded plans, *see supra*, at 10-13, the District Court determined that UBH had breached its fiduciary duty of loyalty as to all class members. [2-ER-332](#) (FFCL). Moreover, because of the conflict and its impact, the District Court also approached with “significant skepticism” UBH’s position that its Guidelines reasonably interpreted the plans’ generally-accepted-standards requirement. [2-ER-330-331](#) (FFCL). The court found UBH’s interpretation was unreasonable, and that UBH had abused its

discretion and breached its duty to make coverage determinations according to plan terms. [2-ER-332-333](#) (FFCL). The District Court found UBH liable under both [29 U.S.C. §§ 1132\(a\)\(1\)\(B\)](#) and [1132\(a\)\(3\)](#). [2-ER-332-34](#) (FFCL); [1-ER-222](#) (Further FFCL) (“Because the CDGs * * * incorporate UBH’s LOCGs, which the Court has found to be more restrictive than generally accepted standards of care, UBH’s use of these CDGs to make benefits determinations was wrongful for the same reasons its use of the LOCGs was wrongful.”).

E. Remedies for UBH’s ERISA Violations

To remedy UBH’s ERISA violations, the District Court issued a declaratory judgment ([1-ER-176-180](#) (Remedies); [1-ER-2-7](#) (Judgment)) and an injunction barring prospective use of the Guidelines and ordering UBH to make clinical coverage determinations using specified criteria that all of the expert witnesses agreed reflected generally accepted standards of care. [1-ER-186-89](#) (Remedies); [1-ER-12-15](#) (Judgment). The court also appointed a special master to monitor UBH’s compliance with the injunction. [1-ER-15](#) (Judgment); [1-SER-3-11](#) (Appointment Order).

To allow UBH to determine for itself whether the class members' specific denials of coverage based in whole or in part on the unlawful Guidelines should be reversed, the District Court remanded the denials to UBH for reprocessing. [1-ER-181-86](#) (Remedies); [1-ER-7-12](#) (Judgment). Thus, the class received the same relief for pre-judgment requests for coverage as it did for new requests, by requiring UBH to apply generally accepted standards of care rather than its flawed Guidelines. Allowing UBH to reprocess the claims after eliminating the Guidelines as a barrier to coverage maintains appropriate deference to UBH, as administrator, to assess whether the clinical facts meet the coverage criteria, while permitting class members to set the record straight on the invalidity of the earlier Guideline-based denials (which may be relevant to future requests) and to obtain reimbursement for care for which UBH determines coverage should have been approved under the correct standard. [1-ER-134-135](#) (Remedies).

SUMMARY OF THE ARGUMENT

I.

Any member of one of the classes could have filed an individual suit against UBH under ERISA for denying a request for coverage based on its Guidelines and sought a declaration that the denial was

unlawful, an injunction against future application of the Guidelines, and a remand to UBH to reprocess the request according to plan terms. The member would have Article III standing because (1) UBH denied a particular request for insurance coverage, triggering a specific dispute about coverage under the member's plan; (2) UBH's breach of its fiduciary and statutory duties is a historically- and congressionally-recognized injury closely tied to monetary loss or loss of treatment—indeed, the historic “no further inquiry” rule itself is enough to establish injury from a fiduciary breach; (3) UBH's reliance in the denial letter on the Guidelines, which the District Court found are not plan terms, withheld information to which the member was entitled under ERISA even without a request; and (4) UBH's reliance on the Guidelines imposed a barrier to obtaining coverage which the member is entitled to remove without first proving that removal will result in payment of benefits.

The member would have a right to sue UBH for equitable relief under the plain terms of [29 U.S.C. §§ 1132\(a\)\(1\)\(B\)](#) and [1132\(a\)\(3\)](#).

There is no textual basis for limiting ERISA claims to monetary relief, and UBH is wrong in trying to portray remands to the administrator for

reprocessing as requiring a judicial determination that benefits are owed. The opposite is true: courts remand out of deference to the administrator's discretion to make coverage determinations after stripping out invalid grounds.

Because each class member could have sued, there is no merit to UBH's contention that class certification "eliminated causation" or violated UBH's substantive rights. Class certification was an efficient use of judicial resources to remedy UBH's unlawful class-wide policy of relying on its Guidelines in place of plan terms—compared to tens of thousands of individual suits, each of which would have required a family to find a lawyer willing to advance litigation expenses (including the costs of hiring experts to analyze the Guidelines, which are not recoverable under this Court's precedents). That is just what class certification is for.

II.

UBH contends the District Court failed to give UBH an appropriate level of deference, but the District Court's factual findings, which UBH does not claim are clearly erroneous, are dispositive.

The District Court did not “[r]ewrit[e] the plans to require coverage consistent with generally accepted standards” ([UBH Br. 45](#)). There was no dispute, and the District Court found, that the plans excluded coverage for treatment that did not comport with generally accepted standards of care, and that UBH used its Guidelines to decide whether that requirement was satisfied. The Guidelines were the same for all the commercial plans UBH administered. The District Court’s determination that the Guidelines were not consistent with generally accepted standards did not prevent UBH from denying coverage based on other plan exclusions. References to UBH’s Guidelines in some plans did not make the Guidelines into plan terms or delegate authority to UBH to negate express plan terms by promulgating guidelines.

UBH also argues for the first time on appeal that the District Court should have applied “substantial evidence” review. ([UBH Br. 50-52](#)). But that kind of review can only be applied if a court is reviewing factual findings made on a defined pre-existing record. UBH did not make factual findings or create a defined record when it developed the Guidelines, so there is nothing for a court to review under that standard. And no court applies a substantial evidence standard to make

findings from its own trial record. ERISA (unlike the APA) does not mention substantial evidence review, but even if the standard properly plays a role in reviewing the record of individual benefits decisions, it has no application here. UBH is also wrong about the evidence; it sought comments from providers, but UBH did not solicit comments on the Guidelines' adherence to generally accepted standards of care, and it disregarded criticisms and proposals, including from its own staff, to adopt criteria that conformed to generally accepted standards.

Even though UBH undisputedly applied the same Guidelines to self-insured and fully-insured plans, UBH argues that a legal rule forbade the District Court from applying to self-insured plans skepticism based on its finding that UBH developed the content of the Guidelines in its own self-interest. [REDACTED]

[REDACTED] and the District Court found that its interest in reducing the amount it had to pay for benefits tainted the Guidelines. Because UBH applied the same tainted Guidelines to all plans, the same skepticism was warranted across the board. It is a factual question whether a conflict of interest infects a fiduciary's interpretation of plan terms, and here the District Court found that

UBH's self-interest in its fully-insured plans infected its decision-making for all plans through the tainted Guidelines.

UBH also argues that the District Court wrongly focused on how the Guidelines were written rather than how they were applied, which UBH claims was more in line with generally accepted standards. But here again, UBH's argument runs afoul of the evidentiary record and the District Court's findings. The District Court found that UBH intended to make, and succeeded in making, coverage decisions based on the Guidelines as written.

III.

UBH contends that the class should have been limited to members who individually exhausted plan remedies, and that the District Court should not have excused what UBH calls "contractual" exhaustion because of futility. UBH argues that when a plan, which is a kind of contract, requires exhaustion there can be no excuse for futility. But the ERISA exhaustion doctrine this Court has applied for forty-plus years is a federal common law rule enforcing contractual (plan) exhaustion requirements, subject to an exception for futility that conforms to background law. An exception for "contractual" exhaustion would be

coextensive with, and would negate, the rule established by longstanding precedent.

UBH's argument also fails for three other reasons. First, this Court does not require exhaustion of statutory ERISA claims, and all the class-wide relief in this case rests on UBH's breach of a statutory fiduciary duty as well as its violation of plan terms. Second, courts have long excused absent class members from exhaustion requirements when the class representatives have exhausted, as they did here. Third, because UBH's denials failed to satisfy ERISA disclosure requirements, class members' remedies should be deemed exhausted.

STANDARD OF REVIEW

This Court reviews the District Court's factual findings for clear error, and its conclusions of law *de novo*. [*Plumber, Steamfitter & Shipfitter Indus. Pension Plan & Tr. v. Siemens Bldg. Techs. Inc.*, 228 F.3d 964, 968 \(9th Cir. 2000\)](#). UBH does not claim any clear error in the District Court's factual findings, making those facts binding on appeal.

When an ERISA plan confers authority on an administrator to interpret the plan, the administrator's interpretation is reviewed for abuse of discretion. [*Saffle v. Sierra Pac. Power Co. Bargaining Unit*](#)

Long Term Disability Income Plan, 85 F.3d 455, 458 (9th Cir. 1996).

The “substantial evidence” standard cited by UBH ([Br. 23](#)), plays no role here, where there was no defined record on review before the District Court. *See infra*, at 57-58.

ARGUMENT

I. UBH’S DENIALS OF COVERAGE INJURED CLASS MEMBERS AND GAVE RISE TO ERISA CLAIMS.

This is not a case about whether Article III or ERISA require causation and traceability, because UBH’s use of its Guidelines to deny a request for coverage is a prerequisite to membership in the classes certified here. [1-ER-213-15](#) (class definitions). UBH uses the term “denial of benefits,” rather than “coverage,” to refer to a monetary loss from paying out-of-pocket for treatment. UBH’s causation analysis thus presumes that only monetary loss constitutes Article III injury, and that the only possible cause of action under ERISA is one for reimbursement of expenses the beneficiary incurred for treatment. But when an insurance company denies a request for coverage in violation of ERISA and its fiduciary duties, the denial itself causes an injury, as well as monetary loss (if the beneficiary pays out of pocket) or other

harm (if the beneficiary cannot pay for the requested services and must accept less effective treatment or go without treatment).

Notwithstanding UBH's "'facial' challenge" label ([UBH Br. 2, 13](#)), the claims in this case were not based on UBH's mere promulgation of its Guidelines. Every class member was prescribed treatment and sought coverage for that treatment under his or her plan, and UBH denied the request based on its Guidelines, which the District Court found to be more restrictive than the plan term they purported to implement. Every such denial of coverage is an Article III injury and triggers a statutory right of action.

A. An ERISA Plan Member Has Article III Standing to Challenge the Denial of a Request for Coverage Based on UBH's Invalid Guidelines, Regardless of Monetary Loss.

By definition, every member of the certified classes had a claim for behavioral health treatment denied by UBH based, in whole or in part, on Guidelines the District Court found violated UBH's fiduciary duties and statutory obligations under ERISA. [1-ER-213-215](#) (class definitions). The classes were limited to individuals whose "request[s] for coverage of residential treatment [or outpatient or intensive outpatient] services for a mental illness or substance use disorder

[were] denied by UBH, in whole or in part,” during the class period, “based upon UBH’s [Guidelines].” [2-ER-236](#) (FFCL). The District Court found that, in fact, each class member’s request for coverage was denied based on UBH’s Guidelines. [2-ER-334](#) (FFCL); [1-ER-3](#), [5](#), [6](#) (Judgment); [2-SER-403-420](#) (TX 894).

Each of UBH’s denials (i.e., its *adverse* benefit determinations, [29 C.F.R. § 2560.503-1\(m\)\(4\)](#)) was a concrete action particular to the family making the request that, like any other insurer’s refusal to provide requested coverage, inflicted a justiciable injury in fact traceable to the invalid Guidelines and redressable by the relief the District Court ordered. Whether that class member went without treatment as a result, or received cheaper, less-intensive treatment that UBH *was* willing to approve, or paid for the requested treatment out of pocket, UBH’s denial of the request for coverage using plan- and ERISA-violating Guidelines was sufficient under Article III for adjudication of the class member’s claim.

Some class members suffered a monetary loss because they paid out of pocket for the treatment after being denied coverage. But, as the Supreme Court’s decision in [Spokeo](#) confirms, Article III injury in fact is

not *limited* to monetary loss, especially when caused by a breach of a fiduciary duty, as here. “To establish injury in fact, a plaintiff must show that he or she suffered an invasion of a legally protected interest that is concrete and particularized and actual or imminent, not conjectural or hypothetical.” [Spokeo v. Robins, 136 S. Ct. 1540, 1548 \(2016\)](#) (cleaned up). The denial of a request for coverage under an ERISA plan is an actual invasion of an interest protected by federal law. See, e.g., [29 U.S.C. §§ 1001\(a\)-\(b\)](#). It is particularized because it affects each class member in a “personal and individual way.” [Spokeo, 136 S. Ct. at 1548](#). And it is concrete in the sense that the Supreme Court means that word: a real interest, but not necessarily a tangible one. [Id. at 1549](#) (“[I]ntangible injuries can nevertheless be concrete.”).

Congress’s judgment and historical practice are important in deciding whether an intangible injury is sufficiently concrete, [id.](#), and both underscore that the class members’ injuries here meet that threshold. When Congress enacted ERISA in 1974, it found that “the continued well-being and security of millions of employees and their dependents are directly affected” by benefit plans like those UBH administers. [29 U.S.C. § 1001\(a\)](#). Congress declared the policy

underlying ERISA to be, among other things, to “protect * * * the interests of participants in employee benefit plans and their beneficiaries, * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.” [29 U.S.C. § 1001\(b\)](#).

Here, each class member suffered the injury Congress identified when it protected health insurance plan beneficiaries from having their claims denied on grounds that violate plan terms and UBH’s fiduciary duties. [29 U.S.C. §§ 1104\(a\)\(1\), 1132\(a\)](#). As for history, as discussed below (*infra*, at 36-37) a breach of fiduciary duty—without any proof of monetary loss—was a justiciable injury at the time of the framing of the Constitution.

UBH characterizes its use of its plan-violating Guidelines to deny requests for coverage as merely “procedural,” [UBH Br. 25-26](#), but this has no bearing on the Article III question.⁷ On remand from the

⁷ As this Court has long recognized, under ERISA, “no great wall divides procedural from substantive violations.” [Pannebecker v. Liberty Life Assur. Co. of Bos.](#), 542 F.3d 1213, 1221 (9th Cir. 2008) (quoting [Blau v. Del Monte Corp.](#), 748 F.2d 1348, 1353 (9th Cir. 1984)).

Supreme Court, this Court in Spokeo had “little difficulty” concluding that violations of the procedural requirements of the Fair Credit Reporting Act were real enough injury to satisfy Article III because the requirements were designed to protect consumers against harm from the dissemination of false information about them. Robins v. Spokeo, Inc., 867 F.3d 1108, 1114 (9th Cir. 2017). The failure to take due care in reporting led to the dissemination of a report about the plaintiff containing false information. Id. at 1118. That was enough—even though the false information (a marriage, graduate degrees, wealth, and a job the plaintiff did not have) might have been considered flattering rather than defamatory—because it was the type of information “that may be important to employers or others making use of a consumer report.” Id. at 1117. On historical practice, this Court found that, despite differences between false credit reports and common law defamation, “Congress has chosen to protect against a harm that is at least closely similar *in kind* to others that have traditionally served as the basis for lawsuit.” Id. at 1115.

Nor was Spokeo unique. See, e.g., Nayab v. Capital One Bank (USA), N.A., 942 F.3d 480, 490-92 (9th Cir. 2019) (reversing dismissal

and finding Article III injury where credit report about the plaintiff was obtained in violation of federal law, even though the report was not disseminated or published); [Ramirez v. TransUnion LLC, 951 F.3d 1008 \(9th Cir. 2020\)](#) (Article III standing for Fair Credit Reporting Act claims based on the creation of erroneous reports that a person was on the OFAC sanctions list).⁸

The same reasoning applies here. ERISA’s “standards of conduct,” including the fiduciary duties of loyalty and to follow plan terms, [29 U.S.C. §§ 1104\(a\)\(1\)\(A\) & \(D\)](#), were designed to protect employees, among other things, from being “deprived of anticipated benefits.” [Id. at § 1001\(a\)](#). UBH’s concrete and specific application of its unlawful Guidelines to each class member’s claim violated plan terms and the statutory standards of conduct designed to protect class members from harm. Just as the [Spokeo](#) plaintiff did not have to show that the false

⁸ The Supreme Court has granted review. *TransUnion LLC v. Ramirez*, No. 20-297 (argued March 30, 2021). But TransUnion’s argument in the Supreme Court principally concerns injury to class members for whom it created but never disseminated a credit report containing the erroneous information. TransUnion contends that in those instances, its failure to take due care in reporting information did not result in any concrete action regarding that class member. Here, every class member received a letter denying a request for coverage based on UBH’s invalidated Guidelines. See [2-ER-252](#) (FFCL).

disclosure caused any additional harm beyond its falsity, [867 F.3d at 1113-16](#), the class members here need not show that the illegal denials caused any additional harm beyond the violation of statutory and fiduciary duties closely associated with monetary loss or loss of the requested treatment. That is Article III injury in fact.⁹

Moreover, just as false credit reports are akin to common law defamation, breaches of statutory fiduciary duty under ERISA are sufficiently “similar in kind” to common law fiduciary breaches to establish Article III standing here as a matter of historical practice. *Cf. Spokeo*, [867 F.3d at 1115](#); *see also infra*, at 36-37.

Multiple, independent, lines of authority predating [Spokeo](#) confirm that UBH’s denials of coverage were Article III injuries.

First, an insurer’s refusal to provide specific coverage under a policy is justiciable regardless of whether the insured turns out to be entitled to coverage, as recognized in many declaratory judgment cases.

⁹ Likewise, there is Article III standing to sue to correct erroneous information in a record under the federal Privacy Act, without obtaining a monetary recovery or proving “actual damages.” *See* [5 U.S.C. § 552a\(g\)\(1\)\(A\)](#) (right to sue for correction of record); [Doe v. Chao](#), [540 U.S. 614 \(2004\)](#) (proof of actual damages required to recover *money* under Privacy Act). At a minimum, reprocessing here will correct the record of the reasons for the denials.

See, e.g., [*Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 243-44 \(1937\)](#); [*Maryland Cas. Co. v. Pac. Coal & Oil Co.*, 312 U.S. 270, 274 \(1941\)](#).

This Court has “consistently held that a dispute between an insurer and its insureds over the duties imposed by an insurance contract satisfies Article III’s case and controversy requirement.” [*Allied Pros. Ins. Co. v. Anglesey*, 680 F. App’x 586, 587 \(9th Cir. 2017\)](#) (quoting [*Gov’t Emps. Ins. Co. v. Dizol*, 133 F.3d 1220, 1222 n.2 \(9th Cir. 1998\)](#) (en banc)).

Embracing this longstanding rule, Congress included a declaratory judgment provision in ERISA. [29 U.S.C. § 1132\(a\)\(1\)\(B\)](#) (right of action to clarify future benefits); [*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 \(1987\)](#) (“Relief may take the form of * * * a declaratory judgment on entitlement to benefits”). The class members’ requests for coverage were denied, and they challenge those denials as violative of their plans, ERISA, and (as to the state mandate class) state law. Those denials constitute cognizable injuries-in-fact.

Second, UBH’s Guidelines imposed an unlawful barrier to coverage, and, as the Supreme Court recently reaffirmed, “an aggrieved party need not allege that he would have obtained the benefit but for the [unlawful] barrier in order to establish standing.” [*Carney v. Adams*](#),

[141 S. Ct. 493, 503 \(2020\)](#) (cleaned up). It has long been the law that to challenge an illegal barrier when seeking a benefit, such as a construction contract (or, in [Carney](#), a state judgeship), the plaintiff need not prove that it would have obtained the benefit if the barrier were removed. See, e.g., [Trinity Lutheran Church of Columbia, Inc. v. Comer](#), [137 S. Ct. 2012, 2022 \(2017\)](#) (church sought to participate in program without a religion-based barrier, without “claiming any entitlement to a subsidy”); [Conservation Force, Inc. v. Manning](#), [301 F.3d 985, 990 & n.3 \(9th Cir. 2002\)](#) (non-resident hunters contesting residency-based barrier to obtaining a hunting tag); [LSO, Ltd. v. Stroh](#), [205 F.3d 1146, 1156 \(9th Cir. 2000\)](#) (requiring only “that the threat of enforcement stood as *one* barrier to the exercise of its First Amendment rights,” and not that it “was the only barrier to finding a venue in California or that LSO would, in fact, find a venue within California but for the threat of enforcement”). Surely UBH would not argue that families could not challenge illegal discrimination against behavioral health treatment, [29 U.S.C. § 1185a](#), or based on race, see [42 U.S.C. § 18116\(a\)](#), unless they could prove that they were owed money for benefits. Likewise, UBH’s excessively-restrictive Guidelines created a

barrier to coverage the classes can challenge irrespective of monetary loss.

Third, history confirms the justiciability of the injury caused by UBH's fiduciary breach. Well before [Spokeo](#), the Supreme Court underscored that "Article III's restriction of the judicial power to 'Cases' and 'Controversies' is properly understood to mean 'cases and controversies of the sort traditionally amenable to, and resolved by, the judicial process,'" and found "history well nigh conclusive" with respect to that question in qui tam cases. [Vt. Agency of Nat. Res. v. U.S. ex rel. Stevens](#), 529 U.S. 765, 774, 777 (2000). History is equally definitive here. For centuries, courts adjudicated breach of fiduciary duty claims with "no further inquiry" into whether the breach caused monetary loss. See [Restatement \(Third\) of Trusts § 78\(1\) & cmt. b.](#)

Under the "no further inquiry" rule, "a beneficiary is given a judgment against a wrongdoing trustee though the beneficiary has not suffered any damage and the trustee has not made any profit from the transaction." [Bogert's Law of Trusts & Trustees § 862 \(Update June 2020\)](#); see also 3 Austin Wakeman Scott et al., *Scott and Ascher on Trusts* § 17.2, at 1080 & n.13 (5th ed. 2007); *Keech v. Sandford*, (1726)

25 Eng. Rep. 223 (Ch.); *Whelpdale v. Cookson*, (1747) 27 Eng. Rep. 856 (Ch.); *Aberdeen Ry. Co. v. Blaikie Bros.*, (1854) 2 L.R. Eq. 1281 (H.L.) 1286-1287 (summarizing cases); [*Michoud v. Girod*, 45 U.S. \(4 How.\) 503, 556 \(1846\)](#) (that rule has “been applied by the English courts of chancery from an early day” and adopted by American courts) (citing [*Davoue v. Fanning*, 2 Johns. Ch. 252 \(N.Y. Ch. 1816\)](#)); [*Jackson v. Smith*, 254 U.S. 586, 588-589 \(1921\)](#); [*Magruder v. Drury*, 235 U.S. 106, 118-120 \(1914\)](#); [*United States v. Carter*, 217 U.S. 286, 307 \(1910\)](#)). That long history confirms that UBH’s breaches of fiduciary duty subjected each class member to justiciable injuries.

Fourth, UBH’s Guideline-based denials caused the class members to suffer informational injury, too. UBH must state the specific reason(s) for any denial and the plan term(s) on which the decision is based. [29 C.F.R. § 2560.503-1\(g\)\(1\)\(i\)&\(ii\)](#).¹⁰ A denial letter that misrepresents plan terms or the basis for denial withholds from the

¹⁰ The Department of Labor’s regulation implements statutory provisions conferring a right to accurate information about plan benefits. *See, e.g.*, [29 U.S.C. § 1021\(a\)](#) (disclosure of summary plan description (“SPD”)); [29 U.S.C. § 1022](#) (contents of SPD); [29 U.S.C. § 1024\(b\)](#) (furnishing of SPD and annual report); [29 U.S.C. § 1133\(a\)](#) (denial notice).

participant accurate information about how the plan applies to the proposed treatment. The class members were misinformed about their denials in two ways. UBH’s invocation of the Guidelines as a basis for denial misleadingly suggested that the Guidelines were plan terms, which they were not. [2-ER-333-334](#), [-253-255](#) (FFCL). UBH’s reliance on its Guidelines to reject coverage also implicitly represented that the prescribed treatment was inconsistent with generally accepted standards of care, but as the District Court found, UBH designed its Guidelines to be far more restrictive than those standards. [2-ER-334](#) (FFCL).

A denial letter stating a ground for denial that is not consistent with the plan—without more—causes injury by withholding information that Congress intended to assure participants would receive, without any need to request it. Courts have long held purely “informational” injury can satisfy Article III. *See, e.g., Fed. Election Comm’n v. Akins*, [524 U.S. 11, 20-25 \(1998\)](#) (plaintiff voters’ “inability to obtain information” that Congress had decided to make public is a sufficient injury in fact to satisfy Article III); *Pub. Citizen v. U.S. Dep’t of Just.*, [491 U.S. 440, 449 \(1989\)](#) (denial of information subject to

disclosure under the Federal Advisory Committee Act “constitutes a sufficiently distinct injury to provide standing to sue”). The Supreme Court reaffirmed the viability of this type of Article III injury in [*Spokeo*](#), [136 S. Ct. at 1549-1550](#). See also [*Southcentral Foundation v. Alaska Native Tribal Health Consortium*](#), [983 F.3d 411, 419 \(9th Cir. 2020\)](#) (injury based on “deprivation of information”).

Contrary to UBH’s argument, [Br. 26-27](#), the Supreme Court did not depart from its own recent holding in [*Spokeo*](#) or its longstanding precedent by imposing an ERISA-specific monetary loss rule in [*Thole v. U.S. Bank, N.A.*](#), [140 S. Ct. 1615 \(2020\)](#). The plaintiffs in that case, beneficiaries in a *defined benefits* pension plan, suffered none of the injuries Plaintiffs here suffered. Although the [*Thole*](#) plaintiffs alleged a breach of fiduciary duty, it was to the *plan* that funded their pensions, not to themselves (as beneficiaries of the plan). [Id. at 1618](#); see [id. at 1623](#) (Thomas, J. concurring) (“In this case, however, none of the rights identified by petitioners belong to them. The fiduciary duties created by ERISA are owed to the plan, not petitioners.”).¹¹ The Court rejected the

¹¹ The [*Thole*](#) plaintiffs offered some theories for why harm to the plan should be deemed harm to the beneficiaries—e.g., that they had a property interest in the plan, or could sue on the plan’s behalf, or that

analogy the *Thole* plaintiffs attempted to draw to the rights of trust beneficiaries to sue for breach of fiduciary duty to a trust, because their rights under a defined benefit plan were materially different from those of both common law trust beneficiaries and beneficiaries of an ERISA defined contribution plan. *Id.* at 1619. In the latter, injury to the plan also injures the beneficiaries, but that is not so for defined benefit plans, where the employer must make good on the benefits promised if there is a shortfall, thereby insulating the beneficiaries from the effects of a fiduciary breach to the plan. *Id.* at 1620; see *id.* at 1622 (no claim made that “the plan and the employer would fail and be unable to pay the plaintiffs’ future pension benefits”). *Thole* does not change Article III law for beneficiaries of an ERISA plan whose own statutory rights were violated.¹²

the violations might otherwise go unchallenged. See [140 S. Ct. at 1620-21](#). The Court’s rejection of those theories, *id.*, has no bearing here, where the harm alleged and proved was to the class members themselves.

¹² UBH ([Br. 39](#)) also cites the district court decision in [Anderson v. Intel Corp., No. 19-CV-04618-LHK, 2021 WL 229235, at *14 \(N.D. Cal. Jan. 21, 2021\)](#), but there, the court found that the allegations of harm were not plausibly traceable to the fiduciaries’ inaccurate disclosures because the plaintiffs did not claim to have read or relied on the defective documents. *Id.* at *13-14. *Anderson* merely reads *Thole* as clarifying that ERISA plaintiffs “must still meet Article III’s standing

Here, UBH breached its statutory and fiduciary duties directly to the beneficiaries whose requests for coverage were denied. *Thole* did not create a monetary loss requirement for such cases. To be sure, “there is no ERISA exception to Article III,” *id. at 1622*. But neither is there an ERISA exception to the Court’s longstanding Article III jurisprudence, discussed above—including the “no further inquiry” rule—and *Thole* did not purport to invent one.

UBH also offers three case-specific factual arguments about Article III injury, each foreclosed by the record.

First, UBH’s contention that class members’ denials that cited a CDG (instead of an LOCG) were not based on the flawed LOCGs ([UBH Br. 28-29](#)) disregards the District Court’s express—and unchallenged—factual findings that the diagnosis-specific CDGs incorporated the flawed, mandatory criteria contained in the LOCGs, [1-ER-216-221](#) (Further FFCL), which are dispositive on this point.

Second, UBH claims that “many” class members’ Guideline-based denials were also “supported by” independent grounds. [UBH Br. 29-30](#).

requirement” even if they seek equitable relief. *Id. at *14*. Here, the District Court found that all class members were denied coverage pursuant to the illegal Guidelines. [2-ER-252](#) (FFCL).

At most, only a tiny fraction of the class received a denial letter that actually cites two independent grounds. UBH identifies only *one* such denial in the claim sample.¹³ But those class members were still injured by UBH’s assertion of the invalid Guideline ground. As explained above, in citing the Guidelines, UBH erected a barrier to coverage that these class members are entitled to remove. *See supra*, at 34-35. The inaccurate denial letters, moreover, did not allow these class members a fair opportunity to assess whether to challenge the independent ground, which they may have done if UBH did not misrepresent that the

¹³ [UBH Br. 29](#) (citing 15-ER-3082 (TX 1302)). The denials for the three other examples UBH offers, *id.*, do not cite any non-Guideline rationale. *See* 3-SER-427-436 (TX 1291) (Member 1060’s denial letter); 3-SER-437-443 (TX 1322) (Member 12102’s denial letter); 15-ER-3069 (Member 6326’s “Decision and Rationale”). UBH cannot now rely on grounds not contained in the denial letter. [Harlick v. Blue Shield of Cal.](#), 686 F.3d 699, 719 (9th Cir. 2012) (administrator may not raise in litigation denial reasons it failed to assert in administrative process).

The paucity of examples of claims actually denied on independent grounds is no surprise: as explained above, at 10, UBH does not even refer coverage requests for clinical review unless there are no administrative grounds for denial. Consistent with that fact, UBH’s lone example of a dual-reason denial cites another *clinical* ground in addition to the Guidelines. *See* 15-ER-3082 (TX 1302) ([REDACTED]); [8-ER-1531:21-1532:7](#) (experimental treatment exclusions require “clinical evaluation”).

requested services did not comply with generally accepted standards.

See supra, at 37-39.

Third, UBH insists that some class members would gain nothing from reprocessing because there is no expense for UBH to reimburse, whether because the request was also denied on an independent ground, or because they did not incur any reimbursable treatment expenses. [UBH Br. 30-31](#). The whole point of reprocessing is to strip away the invalid basis for denial and allow UBH the discretion to determine whether coverage should be approved under “the correct standard.” [Saffle, 85 F.3d at 461](#). That task will be trivial if a letter cites a valid non-Guideline ground; the Remedies Order expressly allows UBH the discretion to uphold such denials. [1-ER-140-146](#) (Remedies).¹⁴ But there is no way to strip the effect of the Guidelines from UBH’s denials of coverage without first reprocessing the claims.

Moreover, as discussed above, at 29-39, neither entitlement to benefits nor monetary loss is an Article III prerequisite. Members who did not receive the requested treatment were injured by having to

¹⁴ Even if such members were excluded from the class, UBH would have to perform exactly the same task—review of the denial letter—to ascertain which members to remove.

accept less-intensive treatment or no treatment. And as the District Court found, such individuals *will* benefit from reprocessing in concrete ways, “because UBH takes into account past treatment and coverage decisions in making further coverage determinations” and thus “a reversal of UBH’s past denial” may “help class members to obtain coverage for future treatment.” [1-ER-136](#) (Remedies). That kind of relief is just like correcting a false credit report or correcting an erroneous government record under the Privacy Act.

B. An ERISA Plan Member has Claims for Equitable Relief under 29 U.S.C. § 1132(a) to Redress the Denial of a Request for Coverage Based on UBH’s Invalid Guidelines.

By definition, UBH denied each class member’s request for coverage based on its Guidelines, which the District Court found were invalid *in toto*. [1-ER-213-215](#) (class definitions); [2-ER-270-310](#), [332](#), [334](#) (FFCL). Far from “excusing” causation, [UBH Br. 24](#), [41](#), the District Court recognized that causation was straightforward in this case.

The District Court found, as fact, that all of the class members’ plans contained a generally-accepted-standards requirement, which UBH administered by applying its Guidelines, [2-ER-247](#), [-253](#) (FFCL); that every class member’s request for coverage was denied, in whole or

in part, based on the Guidelines, [2-ER-252](#), [-334](#) (FFCL); that the Guidelines' Common Criteria were mandatory for all levels of care, such that every class member's request for coverage was subjected to those requirements, [2-ER-246-247](#), [-249-250](#) (FFCL); that the diagnosis-specific CDGs incorporated the flawed, mandatory criteria from the LOCGs, [1-ER-220-221](#) (Further FFCL); and that the Guidelines—including the threshold Common Criteria—were wholly and structurally incompatible with generally accepted standards of care, in multiple overlapping ways, such that every version was “riddled with” excessively restrictive requirements. [2-ER-270-310](#), [-321](#) (FFCL). The upshot of these findings is that when UBH denied coverage based on its Guidelines, it *necessarily* violated the plans and its fiduciary duties.

As above, the premise of UBH's causation argument is that a beneficiary can sue only to recover money to reimburse out-of-pocket payments for treatment caused by the administrator's denial.

The plain text of ERISA forecloses UBH's cramped understanding of the rights and remedies it creates. Congress authorized a beneficiary to bring a civil action not only “to recover benefits due to him under the terms of his plan” but also “to enforce his rights under the terms of the

plan, or to clarify his rights to future benefits under the terms of the plan.” [29 U.S.C. § 1132\(a\)\(1\)\(B\)](#). That right of action is not limited to suing for money. “Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator’s improper refusal to pay benefits.” [Pilot Life Ins., 481 U.S. at 53](#). And if the appropriate relief could not be ordered under [§ 1132\(a\)\(1\)\(B\)](#), then it is available under [§ 1132\(a\)\(3\)](#), which authorizes “appropriate equitable relief” to enforce ERISA or the plan or redress violations. *See* [CIGNA Corp. v. Amara, 563 U.S. 421, 438, 442 \(2011\)](#) (plan-reformation and monetary relief unavailable under [§ 1132\(a\)\(1\)\(B\)](#) may be ordered under [§ 1132\(a\)\(3\)](#)); [Varity Corp. v. Howe, 516 U.S. 489, 512 \(1996\)](#) ([§ 1132\(a\)\(3\)](#) “act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that [[§ 1132](#)] does not elsewhere adequately remedy”).¹⁵ UBH’s denial of

¹⁵ UBH argues that reprocessing is not equitable relief, citing [Almont Ambulatory Surgery Center, LLC v. UnitedHealth Group, No. CV-14-02139-MWF, 2016 WL 6601662, at *11 \(C.D. Cal. Feb. 3, 2016\)](#), but the request in that case was not for reprocessing (i.e., a determination by the administrator whether to approve a claim after stripping away the invalid grounds for denial), but to “properly pay all claims” plaintiffs submitted. Likewise, the court in [Chorosevic v. MetLife Choices, No. 4:05-CV-2394 CAS, 2009 WL 723357, at *11 \(E.D. Mo. Mar. 17, 2009\)](#), understood what it called “reprocessing” to be an

coverage requests based on unlawful Guidelines was a sufficient ground for beneficiaries to seek declaratory and injunctive relief to clarify the right to benefits and to prevent improper denials.

This Court has expressly ruled not only that plaintiffs need not prove entitlement to benefits to obtain reprocessing, but that where, as here, the administrator “misconstrued the [plan] and applied an incorrect standard,” courts should *not* “apply the correct standard to the participant’s claim” and decide whether the plaintiff was entitled to benefits. [Saffle, 85 F.3d at 456, 461](#). Instead, “[i]t should be up to the administrator, not the courts, to make that call in the first instance.” [Id. at 460](#).

injunction to pay money. The reprocessing the District Court ordered here is equitable relief: an injunction directing UBH to decide whether to approve a claim using the right standard. [1-ER-134](#) (Remedies). The fact that UBH might determine after reprocessing that a class member was entitled to benefits does not make the reprocessing injunction an award of money damages. Indeed, even if the District Court had directly ordered payments owed under the plans as properly understood, “the fact that this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief.” [Amara, 563 U.S. at 441](#). See also [Z.D. ex rel. J.D. v. Grp. Health Co-op., No. C11-1119RSL, 2012 WL 5033422, at *11 \(W.D. Wash. Oct. 17, 2012\)](#) (ordering reprocessing in accord with terms of plan reformed to remedy Parity Act violation).

UBH principally relies on an unpublished decision, *Huntsinger v. Shaw Group, Inc.*, 268 F. App'x 518 (9th Cir. 2008), for its causation argument.¹⁶ UBH Br. 31, 32. But all that case stands for is that when an insurer denies benefits pursuant to an undisputedly dispositive exclusion (there, for suicide), it would be futile to remand for a determination of benefits the insurer has no obligation to pay. The beneficiary of the life insurance policy in that case sought neither equitable relief regarding the insurers' policies, nor reconsideration of her claim after stripping away invalid grounds.

Although UBH cites this Court's en banc decision in *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006 (9th Cir. 1997), UBH Br. 34-35, the case actually refutes UBH's theory that a plan administrator cannot be ordered to reconsider benefit claims denied on an erroneous ground if there may be another ground for denial. UBH offers snippets from the opinion, *id.*, but the Court's judgment and holding mirror the District Court's decision in this case. The overarching question was whether

¹⁶ UBH (at 31) also quotes *Lexmark International, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014), but there is no proximate causation issue in this case. UBH's denial letters cite its Guidelines as the reason for denial. The connection is direct, not remote.

Microsoft had properly classified workers as independent contractors, such that it neither withheld taxes from their pay nor offered them employee benefits. [Vizcaino, 120 F.3d at 1009-10](#). The IRS took Microsoft to task, and Microsoft conceded that the workers were employees, but continued to deny them participation in its ERISA plan. [Id.](#) Having determined that the workers were employees and therefore eligible for benefits, the Court remanded to allow the *plan administrator* to determine their eligibility to participate in the ERISA-governed Savings Plus Plan, after stripping away the invalid rationales (that they were not employees and that they waived participation). [Id. at 1013-14](#).

This Court, having rejected the asserted grounds for denial, declined to resolve a different but related question of plan construction (whether the workers were on Microsoft’s “United States payroll”), instead leaving that question to the administrator on remand. [Id.](#) (“[W]e have determined that we should not allow ourselves to be seduced into making a decision which belongs to the plan administrator in the first instance.”). Far from supporting UBH’s argument, [Vizcaino](#) forecloses it. The District Court here did the right thing under this Court’s en

banc precedent by remanding to allow UBH to determine if its other reasons for denying coverage were valid, once the unlawful Guidelines are excised.

This Court's order in [Saffle](#) is to the same effect. See [85 F.3d at 461](#). The [Saffle](#) Court determined that the plan administrator abused its discretion in denying benefits on the ground stated, which misconstrued the plan, [id. at 460](#)—just as here, where UBH abused its discretion in denying coverage based on its invalid guidelines—but did not determine whether benefits were due under the plan, instead remanding to give the plan administrator the opportunity to make that decision. [Id. at 460-61](#). As in [Saffle](#), the remand to UBH is not (and need not be) a directive to award monetary relief in the form of benefits, but instead equitable relief requiring the administrator to eliminate the illegal Guideline-based rationale and then decide if “the claimant would be ‘entitled to the benefits for which she applied’ if the specific questions that required remand were resolved in her favor.” [UBH Br. 33](#) (citing and quoting [Saffle, 85 F.3d at 456-60](#)); see also [Pannebecker, 542 F.3d at 1215](#) (on remand from district court, administrator concluded claimant was not disabled under corrected plan interpretation).

C. The District Court Did Not Violate the Rules Enabling Act by Certifying Classes Whose Members All Had Article III Standing and Common ERISA Claims.

UBH's Rules Enabling Act argument that [Rule 23](#) does not allow a court to certify a class including members who do not have Article III standing or a statutory cause of action has no merit because each class member has both, as explained above. *See supra*, §§ I.A-B. The rest of this section of UBH's brief is not about the Rules Enabling Act, but rather a series of scattershot attacks on class certification. [UBH Br. 42-43](#).

The District Court issued lengthy, careful decisions granting class certification and for the most part denying UBH's post-trial motion for decertification. [2-ER-335-389](#) (Class Cert. Order); [1-ER-191-215](#) (Decert. Order). This Court also denied UBH's [Rule 23\(f\)](#) petition to appeal certification. [Case No. 16-80164, Dkt. 6](#). UBH does not argue that the District Court abused its discretion in making any of the determinations required under [Rule 23\(a\) or \(b\)](#). UBH broadly suggests "that facial challenges to claims administrators' policies are ill-suited to class certification because they fail to meet" [Rule 23](#)'s commonality, typicality, and predominance requirements. [UBH Br. 42](#). But it

identifies no flaw in the District Court's analysis in this case, including in its certification of the classes under [Rule 23\(b\)\(3\)](#).¹⁷ Other courts have similarly certified classes challenging an ERISA administrator's policies. *E.g.*, [Des Roches v. Cal. Physicians' Serv.](#), 320 F.R.D. 486 (N.D. Cal. 2017); [Jones v. United Behavioral Health](#), No. 19-cv-06999-RS, 2021 WL 1318679 (N.D. Cal. Mar. 11, 2021).

None of the rulings UBH cites casts doubt on class certification in this case. In [Dennis F. v. Aetna Life Insurance](#), No. 12-CV-02819-SC, 2013 WL 5377144, at *4 (N.D. Cal. Sept. 25, 2013), the district court found that the challenged decisions were individualized clinical judgments, not applications of mandatory guidelines inconsistent with plan terms. *Compare id.* ("According to Dr. Friedlander, LOCAT scores do not replace clinical judgment. The evidence bears this out."), with [2-ER-247](#) (FFCL) ("UBH employees apply the Guidelines as written, that is, their exercise of clinical judgment is constrained by the criteria for

¹⁷ The District Court certified the classes under [Rule 23\(b\)\(1\), \(2\), and \(3\)](#). [2-ER-372-377](#) ((b)(1)), [2-ER-377-385](#) ((b)(2)), [2-ER-385-389](#) ((b)(3)). Although the court relied specifically on [Rule 23\(b\)\(3\)](#) for the reprocessing remedy, [1-ER-135](#) (Remedies), that was unnecessary. Reprocessing is a form of injunctive relief applicable to the class as a whole. *See* [Fed. R. Civ. P. 23\(b\)\(2\)](#).

coverage set forth in the Guidelines, which are mandatory.”). Nor were any guidelines or standard written policies applied to the putative classes in [*Graddy v. BlueCross BlueShield of Tennessee, Inc.*, No. 4:09-cv-84, 2010 WL 670081 \(E.D. Tenn. Feb. 19, 2010\)](#), or [*Pecere v. Empire Blue Cross & Blue Shield*, 194 F.R.D. 66 \(E.D.N.Y. 2000\)](#).

UBH’s argument that standard policies—like UBH’s Guidelines—that are applied to a class of beneficiaries across the board “are ill-suited to class certification” is also, to say the least, counter-intuitive. [Rule 23\(b\)\(2\)](#) provides for certification of a class if “the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole”—for example, when the opposing party acts pursuant to a uniform policy. In [*Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 353-55 \(2011\)](#), the missing element was a corporate policy—i.e., exactly what the District Court found here. See [*Parsons v. Ryan*, 754 F.3d 657, 688 \(9th Cir. 2014\)](#) (policy applied to entire class although specific effects varied); [*Ballas v. Anthem Blue Cross Life & Health Ins. Co.*, No. CV 12-00604 MMM \(FFMx\), 2013 WL 12119569, at *9 \(C.D. Cal. Apr. 29, 2013\)](#) (claim for insurance coverage

denied pursuant to blanket policy). UBH applied its policy of using its overly-restrictive Guidelines rather than generally accepted standards to the entire class, regardless of which specific guideline it used. All class members were subjected to the same ERISA violations and injured by the same systematic conduct.

UBH ([at 41](#)) quotes out of context a statement from Plaintiffs' attorney's fee application which explains the reasons "no other lawyer" has brought a case like this: ERISA class action suits seeking only equitable relief are costly to litigate even if they are best for clients, but they are less rewarding for counsel than suits producing a common fund—not because the legal theories supporting class-wide equitable relief are suspect or even novel. That statement has no bearing on whether the classes here were properly certified.

UBH inexplicably also tries to invoke the standard for declaring a *statute* facially unconstitutional. [UBH Br. 43](#). But that standard has no relevance to class certification or to whether UBH's Guidelines violated its duties under ERISA to every member of a class whose requests for coverage were denied based on invalid Guidelines. There is also nothing "abstract" or "speculative" about forbidding a health plan administrator

from using invalid guidelines to deny families coverage for treatment and requiring the insurer to reprocess claims that it originally processed under the wrong standards.

II. THE DISTRICT COURT PROPERLY APPLIED THE ABUSE OF DISCRETION STANDARD.

A. The District Court Did Not Rewrite Any Plans or Require Coverage of All Services that Comply with Generally Accepted Standards of Care.

The District Court found that UBH's Guidelines "are not terms of the class members' plans," [1-ER-3](#) (Judgment), and the plans do not authorize UBH "to change the terms of class members' Plans without the approval of Plan sponsors," [2-ER-255](#) (FFCL). If class members' requests for coverage run afoul of other plan terms, like one of the express exclusions UBH mentions ([UBH Br. 47](#)), UBH remains free to apply those terms, including on reprocessing (if UBH invoked them originally, *supra*, at 41-43 & n.13). What UBH cannot do is continue to substitute its Guidelines for plan terms that require adherence to generally accepted standards of care. The District Court's remedial order does not require UBH to provide any coverage not authorized by a plan.

B. The “Substantial Evidence” Standard Did Not Apply to the District Court’s Review of UBH’s Guidelines.

UBH claims the District Court erred by applying the preponderance of the evidence standard to find facts about generally accepted standards based on the trial record. [UBH Br. 50-51](#). According to UBH, the District Court should have confined its review to determining whether “substantial evidence supported UBH’s guidelines.” [Id. at 52](#).

UBH did not argue for its substantial evidence review standard in the District Court. It insisted the District Court had to apply an abuse of discretion standard to UBH’s judgments about the Guidelines, and cited a case referring to substantial evidence. [1-SER-275, -280](#) (UBH’s post-trial brief (excerpt)); [1-SER-269-270, -272](#) (UBH’s proposed findings (excerpt)). But UBH never argued below that “substantial evidence” was the standard for the district court’s fact-finding. The argument, therefore, is forfeited. *See, e.g., Art Attacks Ink, LLC v. MGA Ent. Inc.*, [581 F.3d 1138, 1143 \(9th Cir. 2009\)](#). Indeed, UBH invoked the preponderance standard as Plaintiffs’ burden. [1-SER-278-279](#) (UBH’s

post-trial brief (excerpt)); [1-SER-271](#) (UBH's proposed findings (excerpt)).

Even if the standard of review were appropriately raised, the “substantial evidence” standard does not and could not apply here, where there is no factual finding based on a defined record on review from a prior proceeding. The deference rationale of the substantial evidence standard is inseparable from the process of reviewing a finding previously made in an on-the-record proceeding. A reviewing court refrains from reevaluating the earlier tribunal’s assessment of the credibility or weight of evidence adduced on the record of the earlier proceeding and looks only at whether there was a minimum level of evidence in the record to support a finding, much as a reviewing court leaves those judgments of weight and credibility to a jury in reviewing for sufficiency. To make that kind of judgment, the reviewing court must have before it both a finding and a defined record created by the body whose decision it is reviewing, *see* [5 U.S.C. § 556\(e\)](#) (defining the record). That is why the federal APA applies substantial evidence review *only* to prior on-the-record adversary proceedings under [5 U.S.C. §§ 556](#) and [557](#). [5 U.S.C. § 706\(2\)\(E\)](#). The substantial evidence standard

has no role to play in this case, where the District Court made findings from the trial record about whether the Guidelines are consistent with generally accepted standards, and there is no administrative record on that question.¹⁸

Moreover, the evidence UBH cites as “substantial” support for a conclusion that the Guidelines accurately reflected generally accepted standards ([UBH Br. 52-54](#)) does not even address that question. UBH never asked its commenters to opine on whether the Guidelines were

¹⁸ ERISA, unlike the APA, does not refer to substantial evidence review. This Court has limited abuse of discretion review to the administrative record, [Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 970 \(9th Cir. 2006\)](#) (en banc), but may “consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest.” Some decisions of this Court have applied the substantial evidence standard to the administrative record of individual ERISA disability determinations by analogy to Social Security disability decisions. See [42 U.S.C. § 405\(g\)](#) (administrative law judge’s findings are conclusive if supported by substantial evidence). References in ERISA disability cases to substantial evidence seem to trace back to [Snow v. Standard Insurance Co., 87 F.3d 327, 332 \(9th Cir. 1996\)](#), where the court noted that for purposes of deciding whether the plan administrator’s factual findings in determining the disability claim were clearly erroneous, “the district court was limited to the record before the Plan administrator,” and it should have asked only whether the administrator “abused its discretion by failing to base its decision on substantial evidence” in that record. That has no bearing on this case, where UBH applied a wrongful *standard* (the Guidelines) to deny class members’ requests for coverage.

consistent with generally accepted standards, and there was no evidence that any of them volunteered that they were. [2-ER-317-18](#) (FFCL); [12-ER-2694-2696](#) (TX 1114) (sample of the half-page, 4-question request for “input” in exchange for \$150). The comments UBH touts in its brief offer no view on whether the Guidelines reflect generally accepted standards. And the record shows that UBH disregarded substantive criticisms of its Guidelines. [2-ER-307-309](#), [321-22](#) (FFCL); [10-ER-2162:3-2163:15](#); [10-ER-2195:15-2196:10](#).

The trial record amply supports the District Court’s factual findings, which UBH does not challenge on appeal as clearly erroneous. The District Court found as facts what the generally accepted standards of care require; that UBH’s Guidelines were intentionally more restrictive than those standards; and that UBH acted out of its own self-interest in minimizing benefit expense, not in the sole interest of beneficiaries of the plans it administered, in developing and applying the Guidelines. UBH cannot escape the consequences of those findings by imagining a non-existent adversary proceeding in which UBH found that its Guidelines were consistent with generally accepted standards. UBH cites no case, and we know of none, that applies substantial-

evidence review to the evidentiary record presented (as in this case) to a district court at trial.

C. The District Court’s Skepticism Was Justified by its Factual Findings that UBH’s Self-Interest Actually Tainted the Guidelines UBH Applied to All Plans.

Contrary to UBH’s argument ([Br. 55](#)), there is no legal rule that shields a claims administrator from judicial skepticism when it creates a single set of Guidelines for both fully-insured and self-funded plans and it has a “structural conflict of interest” as to the fully-insured plans, which [REDACTED]

[REDACTED] 15-ER-3016 (FFCL). Whether that conflict warrants skepticism when the administrator applies the same tainted criteria to all plans is a factual question to be answered by the District Court’s findings from record evidence, not a legal one resolved by precedent. *See [Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 117 \(2008\)](#)* (reviewing whether “circumstances suggest a higher likelihood” that conflict had an effect).

UBH itself told the District Court that plaintiffs had to prove that UBH’s conflict of interest with regard to the fully-insured plans “actually influenced” the Guidelines it applied across the board. [1-SER-](#)

[277](#) (UBH’s post-trial brief (excerpt)). The District Court found that it did, holding that “the evidence at trial established that the emphasis on cost-cutting that was embedded in UBH’s Guideline development process actually tainted the process, causing UBH to make decisions about Guidelines based as much or more on its own bottom line as on the interests of the plan members.” [2-ER-331](#) (FFCL); *see also* [2-ER-325-332](#) (FFCL). UBH quibbles with the District Court, [UBH Br. 56-57](#), but does not contend that those findings are clearly erroneous, and the record fully supports them. The District Court’s findings also foreclose UBH’s contention ([at 57-58](#)) that it did not apply the Guidelines as written. [2-ER-242-43](#), [247](#), [251](#) (FFCL).

III. COURTS EXCUSE EXHAUSTION OF ERISA PLAN CONTRACTUAL REMEDIES WHEN IT WOULD BE FUTILE.

UBH’s last claim of error is that the class definitions are overinclusive because they include individuals whose plans, UBH contends, contain “terms unambiguously requiring [them] to exhaust their administrative remedies before filing suit.” [UBH Br. 59](#). UBH concedes that, for more than four decades, courts have excused ERISA plaintiffs from exhausting administrative remedies “when resort to the

administrative route is futile.” [Amato v. Bernard](#), 618 F.2d 559, 568 (9th Cir. 1980); see [UBH Br. 63](#). UBH also concedes that the District Court found, as fact, that requiring the class members to exhaust administrative remedies would be futile—a finding UBH does not contend was clearly erroneous. [2-ER-325](#) (FFCL); see also [2-ER-333](#) (FFCL); [Fallick v. Nationwide Mut. Ins. Co.](#), 162 F.3d 410, 414 (6th Cir. 1998).¹⁹

UBH argues that the well-settled rule excusing exhaustion for futility does not apply where an “exhaustion requirement” is “contractual” as opposed to “prudential.” [UBH Br. 62, 63](#). Precedent leaves no room for a so-called “contractual” exhaustion exception. As explained below, what UBH calls the “prudential” rule is the federal common law doctrine that courts, including this one, long ago adopted

¹⁹ Despite apparently recognizing the futility of seeking reversal of the District Court’s futility findings, UBH dismisses the evidence supporting those findings as “bare assertions of futility.” [UBH Br. 63](#). But as in [Fallick](#), UBH had “consistently defended its long-standing [Guidelines].” [162 F.3d at 420](#). As the District Court found, appeals by more class members would not have led UBH to admit that its Guidelines were unlawful or to amend them. [2-ER-325-26](#) (FFCL); see also [Hitchcock v. Cumberland Univ. 403\(b\) Plan DC Plan](#), 851 F.3d 552, 562 (6th Cir. 2017) (where an ERISA plaintiff challenges a “methodology,” “requir[ing] such a claimant to exhaust administrative remedies * * * misses the point of the dispute”).

to govern exhaustion of plan (i.e., *contractual*) remedies as a prerequisite to suit under ERISA. The scope of the rule (plans with exhaustion requirements) and UBH’s proposed exception for “contractual” exhaustion is the same.

This Court adopted an exhaustion requirement, excused for futility, in [Amato](#) only a few years after Congress enacted ERISA in 1974. That ruling was premised on the existence of a mandatory exhaustion requirement in the plan. Amato was “required to [exhaust] by the terms of the Pension Plan.” [618 F.2d at 566](#); [id. at 562 n.1](#) (providing that any “petition for reconsideration * * * *shall* be filed * * *” and a “failure to file * * * within such sixty day period shall constitute a waiver of the claimant’s right to reconsideration of the decision”) (emphasis added). Although acknowledging that “the text of ERISA nowhere mentions the exhaustion doctrine,” [id. at 566](#), the Court “conclude[d] from both the legislative history and the text of ERISA that Congress did intend to grant such authority to the courts, and that sound policy requires the application of the exhaustion doctrine in suits under the Act.” [Id. at 567](#). The “exhaustion requirement” that [Amato](#) and this Court’s subsequent decisions hold

may be excused where exhaustion would be futile is necessarily a *plan's* requirement of exhausting administrative appeals.

In [Amato](#), this Court held that, “of course” exhaustion may be excused—and a court would “abuse [its] discretion” in not excusing exhaustion—where, for example, “the administrative route is futile.” [618 F.2d at 568](#). And it did so where the plan *did* expressly require members to pursue internal appeals, as noted above. Even the unpublished case UBH cites for the notion that futility “cannot override plan terms,” [Noren v. Jefferson Pilot Fin. Ins. Co., 378 F. App'x 696 \(9th Cir. 2010\)](#) (cited at [UBH Br. 63](#)), made clear that futility excuses exhaustion when a plan “require[s]” appeal; the plan in [Noren](#) “required two levels of internal administrative review.” [Id. at 697-98](#); *see also*, *e.g.*, [Counts v. Am. Gen. Life & Acc. Ins. Co., 111 F.3d 105, 108 \(11th Cir. 1997\)](#) (“The Plan required Counts to appeal * * * [but] district courts have discretion to excuse the exhaustion requirement when resort to administrative remedies would be futile or the remedy inadequate.”).

It is no surprise that implied judicial power to implement plan exhaustion requirements under ERISA is subject to a futility exception,

because even express *statutory* exhaustion requirements may be excused for futility. [*McBride Cotton & Cattle Corp. v. Veneman*, 290 F.3d 973, 978, 982 \(9th Cir. 2002\)](#) (excusing exhaustion as “an idle act” despite statute requiring that “a person shall exhaust all administrative appeal procedures established by the Secretary [of Agriculture] or required by law”); [*Bowen v. City of New York*, 476 U.S. 467, 485 \(1986\)](#) (excusing class members’ failure to exhaust statutory remedies under the Social Security Act for futility).

Other contractual requirements may be waived for futility too. See, e.g., [*L.K. Comstock & Co. v. United Eng’rs & Constructors Inc.*, 880 F.2d 219, 232 \(9th Cir. 1989\)](#) (notice requirement); [*Wolff & Munier, Inc. v. Whiting-Turner Contracting Co.*, 946 F.2d 1003, 1009 \(2d Cir. 1991\)](#) (cure provision); [*Craddock v. Greenhut Constr. Co., Inc.*, 423 F.2d 111, 115 \(5th Cir. 1970\)](#) (“performance bond” requirement). The Supreme Court has squarely held that failure to exhaust mandatory collective bargaining remedies may be excused “for the variety of situations in which doctrinaire application of the exhaustion rule would defeat the overall purposes of federal labor relations policy,” including “where the effort to proceed formally with contractual or administrative remedies

would be wholly futile.” [*Glover v. St. Louis-S.F. Ry. Co.*, 393 U.S. 324, 329-30 \(1969\)](#).

That was the background law when Congress passed ERISA. *See also* [*Parish v. Legion*, 450 F.2d 821, 827 \(9th Cir. 1971\)](#) (“It is unnecessary to pursue interunion remedies when it is clear, as in this case, that to do so would be futile.”). As this Court explained in [*Amato*](#), when Congress enacted ERISA, it did so in the expectation that courts would implement “all actions under ERISA to enforce benefit rights under a covered plan or to recover benefits under the plan, whether brought in federal or state courts, ‘* * * as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947,’” i.e., consistent with federal common law. [*Id.* at 567](#). When even express statutory exhaustion requirements were excused for futility, it is little wonder that in adopting a common-law requirement to exhaust plan remedies under ERISA, courts likewise did not require acts of futility.

UBH’s attack on the class definition also fails for three other independent reasons.

First, the named Plaintiffs and many class members did exhaust internal appeals, and the District Court did not clearly err or abuse its discretion in “excus[ing]” exhaustion by *other* class members, having found that “the claims of named Plaintiffs put UBH on notice of the absent class members’ claims, thus fulfilling the purposes of UBH’s internal grievance procedure.” [2-ER-325](#) (FFCL). See [Diaz v. United Agric. Emp. Welfare Benefit Plan](#), 50 F.3d 1478, 1483 (9th Cir. 1995). Where, as here, the wrongdoing involves common, class-wide conduct such as UBH’s use of fundamentally flawed Guidelines, any exhaustion requirements are satisfied by named Plaintiffs’ exhaustion of administrative remedies. [In re Household Int’l Tax Reduction Plan](#), 441 F.3d 500, 501-02 (7th Cir. 2006) (Posner, J.). Accord [Leon v. Standard Ins. Co.](#), No. 2:15-cv-07419-ODW(JC), 2016 WL 768908, at *4 (C.D. Cal. Jan. 28, 2016); [Barnes v. AT&T Pension Ben. Plan-Nonbargained Program](#), 270 F.R.D. 488, 494 (N.D. Cal. 2010); [Thomas v. SmithKline Beecham Corp.](#), 201 F.R.D. 386, 395 (E.D. Pa. 2001); [Laurenzano v. Blue Cross & Blue Shield of Mass., Inc. Ret. Income Tr.](#), 134 F. Supp. 2d 189, 211 (D. Mass. 2001).

UBH points to four unpublished decisions from courts in other circuits it claims “rejected that rule.” [UBH Br. 60](#) (citing [Schmookler v. Empire Blue Cross & Blue Shield](#), 107 F.3d 4 (2d Cir. 1997) (table); [Stephens v. U.S. Airways Grp., Inc.](#), No. 07-cv-1264 (RMC), 2012 WL 13054263, at *3 (D.D.C. July 18, 2012); [Churchill v. Cigna Corp.](#), Civ. No. 10-6911, 2011 WL 3563489, at *7 (E.D. Pa. Aug. 12, 2011); [Coffin v. Bowater Inc.](#), 228 F.R.D. 397, 404 (D. Me. 2005)). Two of UBH’s cases ([Schmookler](#) and [Churchill](#)) did not even address whether named plaintiffs’ exhaustion should excuse class members’ failure to exhaust; and [Churchill](#) involved a proposed class of individuals who had not submitted requests for coverage in the first place. [2011 WL 3563489, at *7](#). The two that arguably addressed the question did so with no analysis whatsoever. [Coffin, 228 F.R.D. at 404](#) (“the Court has required any person wishing to participate in this lawsuit to exhaust”); [Stephens, 2012 WL 13054263, at *3](#) (brushing off contrary authority as not “particularly persuasive”). Moreover, the D.C. Circuit reversed the denial of class certification in [Stephens](#) without reaching the class exhaustion question, holding (in agreement with this Circuit) that exhaustion was not required because the claims were statutory.

Stephens v. Pension Ben. Guar. Corp., 755 F.3d 959, 966 (D.C. Cir. 2014).

Second, all of the class-wide relief is supported independently by a claim that is not subject to exhaustion, because “as a general rule, exhaustion is not required for statutory claims.” *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1294 (9th Cir. 2014). Any exhaustion requirement thus would not apply to Plaintiffs’ breach of fiduciary duty claim.²⁰ *Fujikawa v. Gushiken*, 823 F.2d 1341, 1345 (9th Cir. 1987) (reversing failure-to-exhaust dismissal because “[e]xhaustion of internal dispute procedures is not required where the issue is whether a violation of the terms or provisions of [ERISA] has occurred”); *Amaro v. Cont’l Can Co.*, 724 F.2d 747, 751-52 (9th Cir. 1984), *overruled on other grounds by* *Dorman v. Charles Schwab Corp.*, 934 F.3d 1107 (9th Cir. 2019) (ERISA retaliation claim). *See also* *Williams v. Pac. Mar. Ass’n*, 617 F.2d 1321, 1328 (9th Cir.

²⁰ In *Spinedex*, for example, the breach of fiduciary duty claim encompassed United’s failure to “implement and apply administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with the plan documents.” Second Am. Class Action Compl. at ¶ 112(d), *Spinedex*, No. CV 08-457-PHX-ROS, 2008 WL 7154677 (D. Ariz. July 9, 2008).

[1980](#)) (explaining in the labor context that even if parties asserting a violation of a collective bargaining agreement must exhaust administrative remedies, alleged breaches of a “statutory duty” as such “are not subject to exhaustion”).

Of course, a claimant may not simply “attach a ‘statutory violation’ sticker to his or her claim and then * * * use that label as an asserted justification for a total failure to pursue the congressionally mandated internal appeal procedures” for a claim “under a particularized set of facts.” [Diaz, 50 F.3d at 1483-84](#). See also [Spinedex, 770 F.3d at 1294](#) (exhaustion is required for “‘disguised’ claim[s] for benefits”). But the District Court found that Plaintiffs’ breach of fiduciary duty claim was *not* a “disguised claim for benefits”; but rather sought appropriate equitable relief, including reprocessing, to remedy UBH’s breaches of fiduciary duty. See, e.g., [1-ER-78](#) (Summary Judgment); [2-ER-238](#) & [-332](#) (FFCL).

Third, the class members should be “deemed” to have exhausted in any event, because of the same deficiencies in their denial letters that caused informational injury. See *supra*, at 37-39; [Spinedex, 770](#)

[F.3d at 1299](#) (citing [29 C.F.R. § 2560.503-1\(d\)](#)); [2-ER-236](#) (FFCL)

(declining to reach deemed exhaustion question).

CONCLUSION

The District Court's judgment should be affirmed.

Dated: May 12, 2021

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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ADDENDUM

Pursuant to Circuit Rule 28-2.7, Plaintiffs-Appellees submit this addendum of additional applicable statutory provisions, reproduced verbatim, in some instances excerpted as noted.

5 U.S.C. § 552a(g)(1)(A).....	2a
5 U.S.C. § 556(e)	2a
5 U.S.C. § 706(2)	2a
29 U.S.C. § 1001	3a
29 U.S.C. §§ 1002(14)(A) & (21)	5a
29 U.S.C. § 1021(a).....	6a
29 U.S.C. § 1022	6a
29 U.S.C. § 1024(b)	8a
29 U.S.C. § 1104(a).....	10a
29 U.S.C. § 1133	11a
29 U.S.C. § 1185a	12a
42 U.S.C. § 405(g).....	18a
42 U.S.C. § 18116(a).....	19a
29 C.F.R. §§ 2560.503-1(a), (e), (g)(1), (l) & (m)(4).....	20a

5 U.S.C. § 552a(g)(1)(A)

5 U.S. Code § 552a – Records maintained on individuals

***** (g)**

(1) Civil Remedies.—Whenever any agency

(A) makes a determination under subsection (d)(3) of this section not to amend an individual’s record in accordance with his request, or fails to make such review in conformity with that subsection;

5 U.S.C. § 556(e)

5 U.S. Code § 556 – Hearings; presiding employees; powers and duties; burden of proof; evidence; record as basis of decision

***** (e)** The transcript of testimony and exhibits, together with all papers and requests filed in the proceeding, constitutes the exclusive record for decision in accordance with section 557 of this title and, on payment of lawfully prescribed costs, shall be made available to the parties. When an agency decision rests on official notice of a material fact not appearing in the evidence in the record, a party is entitled, on timely request, to an opportunity to show the contrary.

5 U.S.C. § 706(2)

5 U.S. Code § 706 – Scope of review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

*** **(2)** hold unlawful and set aside agency action, findings, and conclusions found to be—

- (A)** arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
- (B)** contrary to constitutional right, power, privilege, or immunity;
- (C)** in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
- (D)** without observance of procedure required by law;
- (E)** unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
- (F)** unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

29 U.S.C. § 1001

29 U.S. Code § 1001 – Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the

stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries. It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance. It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C. §§ 1002(14)(A) & (21)

29 U.S. Code § 1002 – Definitions

For purposes of this subchapter * * *

(14) The term “party in interest” means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

* * *

(21)

(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the

administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

29 U.S.C. § 1021(a)

29 U.S. Code § 1021 – Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries. The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 1022(a)(1) [1] of this title; and

(2) the information described in subsection (f) and sections 1024(b)(3) and 1025(a) and (c) of this title.

29 U.S.C. § 1022

29 U.S. Code § 1022 – Summary plan description

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title), the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title), and if the employer so elects for purposes of complying with section 1181(f)(3)(B)(i) of this title, the model notice applicable to the State in which the participants and beneficiaries reside.

29 U.S.C. § 1024(b)

29 U.S. Code § 1024 – Filing with Secretary and furnishing information to participants and certain employers

***** (b) Publication of summary plan description and annual report to participants and beneficiaries of plan.** Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section 1022(a) of this title—

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 1022 of this title which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply.

Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 1022 of this title every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 1022(a) of this title (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 1191b(a)(1) of this title)), a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is

adopted to each participant, and to each beneficiary who is receiving benefits under the plan. If there is a modification or change described in section 1022(a) of this title that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 1191b(a)(1) of this title), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after August 21, 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.

(2) The administrator shall make copies of the latest updated summary plan description and the latest annual report and the bargaining agreement, trust agreement, contract, or other instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administrator and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations).

(3) Within 210 days after the close of the fiscal year of the plan, the administrator (other than an administrator of a defined benefit plan to which the requirements of section 1021(f) of this title applies) [1] shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraphs (A) and (B) of section 1023(b)(3) of this title and such other material (including the percentage determined under section 1023(d)(11) of this title) as is necessary to fairly summarize the latest annual report.

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated

summary,[2] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

(5) Identification and basic plan information and actuarial information included in the annual report for any plan year shall be filed with the Secretary in an electronic format which accommodates display on the Internet, in accordance with regulations which shall be prescribed by the Secretary. The Secretary shall provide for display of such information included in the annual report, within 90 days after the date of the filing of the annual report, on an Internet website maintained by the Secretary and other appropriate media. Such information shall also be displayed on any Intranet website maintained by the plan sponsor (or by the plan administrator on behalf of the plan sponsor) for the purpose of communicating with employees and not the public, in accordance with regulations which shall be prescribed by the Secretary.

29 U.S.C. § 1104(a)

29 U.S. Code § 1104 – Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries;
and

- (ii) defraying reasonable expenses of administering the plan;
- (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
- (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III.

29 U.S.C. § 1133

29 U.S. Code § 1133 – Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
- (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1185a

29 U.S. Code § 1185a – Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B)

and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations.

(A) In general. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions. In this paragraph:

(i) Financial requirement. The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation. The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information. The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers. In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage

for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) Construction. Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions [omitted]

(d) Separate application to each option offered. In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions. For purposes of this section—

(1) **Aggregate lifetime limit.** The term “aggregate lifetime limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) **Annual limit.** The term “annual limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan

or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits. The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits. The term “mental health benefits” means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits. The term “substance use disorder benefits” means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(f) Secretary report. The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

(g) Notice and assistance. The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform

participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.

42 U.S.C. § 405(g)

42 U.S. Code § 405 – Evidence, procedure, and certification for payments

***** (g) Judicial review.** Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer,

remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

42 U.S.C. § 18116(a)

42 U.S. Code § 18116 – Nondiscrimination

(a) In general. Except as otherwise provided for in this title [1] (or an amendment made by this title),[1] an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or

amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

29 C.F.R. §§ 2560.503-1(a), (e), (g)(1), (l) & (m)(4)

Claims procedure

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

* * *

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

* * *

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv), or with the standards imposed by 29 CFR 2520.104b-31 (for pension benefit plans). The

notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan—

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical

circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

* * *

(l) Failure to establish and follow reasonable claims procedures.

(1) In general. Except as provided in paragraph (l)(2) of this section, in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) Plans providing disability benefits [omitted]

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

* * *

(4) The term “adverse benefit determination” means:

(i) Any of the following: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of,

or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and

(ii) In the case of a plan providing disability benefits, the term “adverse benefit determination” also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term “rescission” means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage * * * .