

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

BARBARA BEACH, et al.,

Plaintiffs,

v.

UNITED BEHAVIORAL HEALTH,

Defendant.

Case No. 21-cv-08612-RS

**ORDER DENYING MOTION TO
DISMISS OR STRIKE**

I. INTRODUCTION

Plaintiffs¹, the participants and beneficiaries of health care plans administered by Defendant United Behavioral Health (“UBH”), aver that the company violated its fiduciary duties and the terms of their insurance plans by deliberately designing policies to reduce the number and value of claims that it would approve. Citing various portions of the Employee Retirement Income Security Act of 1974 (“ERISA”), Plaintiffs seek declaratory and injunctive relief—including the reprocessing of some claims that UBH denied.

Defendant moves to dismiss the complaint or, in the alternative, to strike those portions of the complaint that seek claim reprocessing. For the reasons explained below, the motion is denied.

¹ Plaintiffs include Barbara Beach and five other beneficiaries of plans administered by UBH. With court approval, those five are proceeding anonymously in this action as John Doe, John Loe, John Poe, John Roe, and John Zoe. *See* Dkt. No. 18.

II. BACKGROUND

A. Generally Accepted Standards of Care and Defendant's Alleged Practices

Plaintiffs are participants and beneficiaries of employer-sponsored health benefit plans governed by ERISA and administered by Defendant. All of the plaintiffs' plans cover treatment for sickness, injury, mental illness, and substance use disorders along a spectrum of services that include those at the residential treatment, partial hospitalization, and intensive outpatient levels of care. Each Plaintiff's plan requires, as an essential prerequisite of coverage, that services be consistent with generally accepted standards of care ("GASC"). Plaintiffs assert that Defendant developed internal Level of Care ("LOC") Guidelines to implement the GASC requirement in the plans that it administered.

1. Generally Accepted Standards of Care

According to Plaintiffs, numerous sources for GASC exist "for matching patients with the most appropriate and effective level of care for treating patients' mental health conditions and substance use disorders. Am. Compl., Dkt. No. 59 ¶ 40-41 (hereafter, "AC"). These sources allegedly show that GASC include certain standards, including eight that Plaintiffs highlight in their complaint. Plaintiffs claim those particular standards recognize that effective treatment of substance use disorders is not limited to alleviating current symptoms and that behavioral health diagnoses require comprehensive, coordinate treatment of all co-occurring conditions; Plaintiffs also assert, *inter alia*, that it is a GASC to err on the side of caution by placing patients in a higher level of care when there is ambiguity as to which level is appropriate, and that there is no specific limit to the duration of a behavioral health disorder treatment—"it is inconsistent with [GASC] to require discharge as soon as a patient becomes unwilling or unable to participate in treatment." *Id.* ¶ 41. *See also Wit v. United Behav. Health*, No. 14-cv-02346-JCS, 2019 WL 1033730, at *17-*22 (N.D. Cal 2019), *aff'd in part, rev'd in part and remanded*, 79 F.4th 1068 (9th Cir. 2023) (hereafter, "Wit Findings of Fact and Conclusions of Law" or "FFLC") (finding, by a preponderance of the evidence, that the standards Plaintiffs identify in their complaint are generally accepted in the fields of mental health and substance use disorder treatment).

2. The Guidelines, Defendant's Allegedly Too-Narrow Version of GASC

According to the operative complaint, Defendant (during the at-issue period) exercised its discretion by developing, adopting, and applying its own clinical criteria to implement the GASC, eschewing the independent, publicly available sources that Plaintiffs identify and summarize in their complaint. At the time Plaintiffs' coverage requests were denied, the clinical criteria UBH used to interpret the Plan GASC requirements, and which it applied in making clinical coverage determinations, were the UBH Level of Care Guidelines ("LOC" Guidelines).

In a separate case, a group of similar plaintiffs represented by the same counsel challenged the 2011 through 2017 editions of the LOC Guidelines. *See generally, Wit FFCL*, 2019 WL 1033730. Although the Ninth Circuit ultimately reversed the *Wit* trial court on several key issues, it found no error in the trial court's conclusion "that UBH abused its discretion because the challenged portions of the Guidelines did not *accurately* reflect GASC." *Wit v. United Behav. Health*, 79 F.4th 1068, 1088 n.6 (9th Cir. 2023). A similar group of plaintiffs is challenging denials based on the 2017 Guidelines that occurred after the close of the class period in *Wit*. *See generally, Jones v. United Behav. Health*, No. 19-cv-69999, 2021 WL 1318679, at *1 (N.D. Cal. 2021).

In this case, Plaintiffs challenge the 2018 and 2019 Guidelines as "only slightly revised version of the Guidelines invalidated in the *Wit* Litigation," asserting that they "result from the same self-interested development process [and] suffer from the same fatal defects as the 2011 through 2017 editions." AC ¶ 53. Plaintiffs' claims were denied from May 9, 2018 until January 30, 2020 under the 2018 and 2019 Guidelines that allegedly feature the same incongruences with the GASC that Plaintiffs describe in their complaint, as explained *supra*. They assert that Defendant deliberately made its Guidelines more restrictive than GASC, including with respect to the eight ways identified in the complaint and discussed in *Wit FFCL*, so that it could deny more claims and make more money.

Moreover, Plaintiffs aver that these overly narrow Guidelines caused them harm. Each Plaintiff was denied coverage under their Plan for residential treatment based on a purported

1 failure to satisfy UBH’s Guidelines. Plaintiffs exhausted internal appeals, only to reach the same
2 result based on the same Guidelines—meaning that UBH’s allegedly too-narrow Guidelines were
3 the basis for the denial of full coverage in each case.

4 **3. The Bundling Policy, Defendant’s Facility-Based Reimbursement Rule**

5 Defendant also allegedly implemented a “Facility-Based Behavioral Health Program
6 Reimbursement Policy” inconsistent with Plaintiffs’ plans’ written terms that provided coverage
7 for medically necessary services. Plaintiffs aver that this so-called “Bundling Policy” required
8 facilities to submit claims for reimbursement for facility-based care using a daily rate that
9 accounted for all services provided at a given level of care—rather than itemizing individual
10 services, some of which may have been provided at a lower level of care. As a result, Plaintiffs
11 claim, Defendant sometimes denies all coverage for all services in a claim due to them not being
12 medically necessary even where some of the services *are* medically necessary at the lower level of
13 care. Indeed, UBH even identified that some of the claimed services were appropriate at a lesser-
14 included level of care, suggesting that, if that service had been submitted independently, it would
15 have been approved.

16 For example, Plaintiff Beach’s claim for mental health residential treatment for her suicidal
17 daughter was denied after an initial twelve-day treatment in November 2019. AC ¶ 75–76. Her
18 denial and initial appeal denial notice allegedly state that “care could continue at partial
19 Hospitalization Program” or “her care could have continued in a less intensive setting.” Internal
20 UBH records allegedly state that Beach’s daughter was authorized to seek mental health PHP. *See*
21 *id.* ¶ 77–80. In other words, Plaintiffs assert that “UBH denied coverage for the services in full,
22 despite its own finding that Ms. Beach’s daughter needed ongoing treatment.” *Id.* ¶ 98.
23 Complicating matters further, Plaintiffs aver that Defendant did not inform them that their denials
24 were being denied due to the Bundling Policy, nor explain how they could appeal that
25 determination. The only provided basis for denial was the Guidelines, aka UBH’s “Medical
26 Necessity criteria for Mental Health Residential Treatment Center Level of Care.” *See id.* ¶ 77;
27 *see also* ¶ 80 (“Mental Health Residential Level of Care”); ¶ 82 (“Optum Level of Care Guideline
28

for Mental Health Residential and Optum Common Criteria for Clinical Best Practices for All Levels of Care Guidelines”); ¶ 87 (“Level of Care Guidelines”). Those Guidelines are the subject of other claims in Plaintiffs’ complaint, but they do not address the Bundling Policy that Plaintiffs identify.

B. Plaintiffs’ Claims

Based on the above allegations, Plaintiffs assert four claims: (1) breach of fiduciary duty, (2) wrongful denial of benefits, (3) wrongful denial of benefits due to bundling, and (4) failure to establish and follow reasonable claims procedures.

1. Breach of Fiduciary Duty

Like the *Wit* plaintiffs, Plaintiffs here aver that UBH is an ERISA fiduciary that owes them, as ERISA plan members, the duty to carry out its work solely in their interest and with reasonable prudence and care. *See* 29 U.S.C. § 1104(a). They allege that UBH breached those duties by allowing its own financial self-interest to infect its development of the Guidelines and by deliberately adopting them as its standard medical-necessity criteria for implementing plans’ GASC requirements—even though the Guidelines were much more restrictive than GASC—in order to increase profits by reducing the amount of benefits paid out to plan participants and beneficiaries. The same argument, Plaintiffs aver, applies to the Facility-Based Behavioral Health Program Reimbursement Policy, aka the “Bundling Policy” that likewise allegedly enabled UBH to minimize the amount of benefits paid and maximize the business benefits of denying coverage.

2. Wrongful Denial of Benefits

Plaintiffs separately aver that UBH denied their claims in an arbitrary and capricious manner by implementing their plans’ GASC requirements through overly restrictive Guidelines. They claim they might have been entitled to benefits if UBH had applied guidelines consistent with the GASC that their plans required. AC ¶ 45. As part of this claim, Plaintiffs highlight that Defendant provided no administrative review procedure that would enable them to challenge the content of the Guidelines, as opposed to simply appealing the outcome of an individual claim. Given that they had no way to challenge the Guidelines themselves, Plaintiffs believe their claims

are deemed exhausted under ERISA's implementing regulations. *See* 29 C.F.R. § 2560.503-1(g) & (l).

3. Wrongful Denial of Benefits due to Bundling

Distinct from their allegations about the Guidelines, Plaintiffs aver arbitrary and capricious denial of benefits inasmuch as denials resulted from the application of UBH's Bundling Policy. They argue that it is unreasonable for UBH to have a policy of denying coverage for all facility-based services whenever it rejected coverage for treatment at a particular level of care, in lieu of considering whether to cover some of the services on an un-bundled basis or whether to cover the value of the lesser-included level of care. Because the underlying plans do not exclude coverage for these lesser levels of care when they are medically necessary simply because the member received additional behavioral health services that are being denied, Plaintiffs assert that their claims were wrongfully denied.

4. Failure to Establish and Follow Reasonable Claims Procedures

Plaintiffs' final claim is that UBH did not adequately notify them of the Bundling Policy basis for their denials as required by ERISA. *See* 29 U.S.C. § 1133 (requiring plan fiduciaries to "provide adequate notice in writing" of "the specific reasons" for any benefit denial, "written in a manner calculated to be understood" by the plan participant or beneficiary, and to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review" of the denial). According to Plaintiffs, UBH failed to disclose in an understandable manner that some coverage requests were denied based on the Bundling Policy. It also allegedly failed to disclose any information on how Plaintiffs or Class members could perfect claims for the lesser-included component services.

C. Requested Relief

As relief, Plaintiffs seek a declaration that UBH's 2018 and 2019 Level of Care Guidelines are not consistent with GASC; a declaration that denials based on bundling requirements violate ERISA and the terms of Plaintiffs' plans; an injunction to enjoin UBH from denying benefits for otherwise-covered services based on its Bundling Policy and to enjoin UBH from using guidelines

or criteria more restrictive than GASC to implement any ERISA plan's requirement that services be GASC-consistent; class-specific orders requiring UBH to reprocess claims that it denied pursuant to Guidelines that were inconsistent with GASC or pursuant to its Bundling Policy; and other appropriate equitable relief.

1. Guideline Denial Class and Reprocessing Relief Subclass

With respect to their claim for arbitrary and capricious denial of benefits due to excessively restrictive Guidelines, Plaintiff seeks to certify a Guideline Denial Class with Plaintiffs Beach, Doe, Loe, Poe, Roe, and Zoe as Class Representatives, defined as follows:

Any member of a health benefit plan governed by ERISA whose request for coverage of residential treatment services for a mental illness or substance use disorder, or any portion thereof, was denied by UBH, between February 8, 2018 and the present, based upon UBH's Level of Care Guidelines, and was not subsequently approved in full following an administrative appeal.

The Guideline Denial Class excludes any member of a fully-insured plan governed by both ERISA and the state law of Connecticut, Rhode Island, or Texas, whose request for coverage of residential treatment was related to a substance use disorder, except that the Class includes members of plans governed by the state law of Texas who were denied coverage of substance use disorder services sought or provided outside of Texas.

Plaintiff separately seeks to certify a Guideline Denial Reprocessing Subclass, within the above class, and represented by the same named Plaintiffs, pursuant to their requested order for reprocessing of claims allegedly denied due to the challenged Guidelines. This Subclass is defined as follows:

Any member of the Guideline Denial Class who incurred expenses for residential treatment for which benefits were not paid, except that the Reprocessing Subclass shall not include class members whose written notification of denial, as reflected in UBH's records, (a) identifies a reason for denying the request for coverage other than the class member's failure to satisfy UBH's Level of Care Guidelines, and/or (b) specifies that the member's failure to satisfy the applicable Guideline was based solely on a portion of the Guideline that was unchallenged in this action.

2. Bundled Denial Class and Reprocessing Subclass

Distinct from the Guideline Denial Class, Plaintiffs seek to certify a “Bundled Denial Class” pursuant to their claims about the Bundling Policy, represented by the same named plaintiffs and defined as follows:

Any member of a health benefit plan governed by ERISA whose request for coverage of residential treatment services for a mental illness or substance use disorder was denied in full by UBH, between February 8, 2018 and the present and was not subsequently approved in full following an administrative appeal, and (a) whose written notification of denial states that services would be appropriate or could be provided at the partial hospitalization, intensive outpatient, or outpatient level of care; and (b) whose request for coverage of residential treatment UBH denied on a bundled, “per diem” basis rather than either approving services at the applicable rate for the alternative level of care UBH identified in its denial letter or approving coverage for any component services enumerated in the plan and provided as part of the residential treatment program for which coverage was requested.

Within the Bundled Denial Class, Plaintiffs seek to certify a subclass represented by the same named plaintiffs pursuant to their requested order for reprocessing of claims allegedly denied due to the challenged Guidelines. This Subclass is defined as follows:

Any member of the Bundled Denial Class who incurred unreimbursed expenses for covered behavioral healthcare services, provided at a residential treatment facility, that were equivalent to services UBH stated were appropriate or could be provided to the member, but for which UBH denied coverage on a bundled, “per diem” basis as stated in the Bundled Denial Class definition above.

Plaintiffs assert that the membership of all these classes and related subclasses is objectively ascertainable through the use of UBH’s own files and the denial letters they each received for their claims.

Defendant moves to dismiss all four claims in the complaint, or in the alternative, to strike Plaintiffs’ request for reprocessing relief.

III. LEGAL STANDARD

A. Motion to Dismiss

A complaint must contain “a short and plain statement of the claim showing that the pleader is entitled to relief.” Fed. R. Civ. P. 8(a)(2). While “detailed factual allegations” are not required, a complaint must have sufficient factual allegations to state a claim that is “plausible on its face.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555, 570 (2007)). Dismissal under Rule 12(b)(6) may be based on either the “lack of a cognizable legal theory” or on “the absence of sufficient facts alleged under a cognizable legal theory.” *See Conservation Force v. Salazar*, 646 F.3d 1240, 1242 (9th Cir. 2011) (internal quotation marks and citation omitted). When evaluating such a motion, the court must accept all material allegations in the complaint as true and construe them in the light most favorable to the non-moving party. *In re Quality Sys., Inc. Sec. Litig.*, 865 F.3d 1130, 1140 (9th Cir. 2017). It must also “draw all reasonable inferences in favor of the nonmoving party.” *Usher v. City of Los Angeles*, 828 F.2d 556, 561 (9th Cir. 1987).

B. Motion to Strike

A court may strike from a pleading any redundant, material, impertinent, or scandalous matter. Fed. R. Civ. P. 12(f).

IV. DISCUSSION

A. Fiduciary Duty Claim

Plaintiffs sufficiently plead their breach of fiduciary duty claim. To state a claim for breach of fiduciary duty under ERISA, Plaintiffs must plausibly allege that: “(1) UBH was a Plan fiduciary; (2) UBH breached its fiduciary duty; and (3) the breach caused harm to Plaintiffs.” *Wit FFCL*, 2019 WL 1033730, at *51. Defendant does not contest its fiduciary status and instead focuses on the alleged harm, asserting that it is insufficiently substantive. The operative complaint, however, specifically outlines multiple substantive ways that UBH’s fiduciary breaches harmed Plaintiffs—that is, allegedly putting its bottom line ahead of beneficiaries’ and members’ interests by developing the overly restrictive Guidelines and Bundling Policy to reduce the

instance of paying claimants. *See* AC ¶ 184 (describing harms that include a material risk to their interest in the benefits promised by their Plans; a material risk to have those Plans’ terms administered in their best interests and in accordance with said terms; a material risk that the claims will be administered under policies that impermissibly narrow the scope of their benefits, and the present harm that such policies have made it impossible for Plaintiffs to know the scope of coverage their Plans will actually provide). The Ninth Circuit found these same harms to be sufficiently pronounced to establish standing for the plaintiffs challenging the 2011 through 2017 Guidelines. *Wit*, 79 F.4th at 1082–83. Its reasoning likewise supports the plausibility of their allegations of harm derived from the 2018 and 2019 Guidelines, as well as those harms they aver from the implementation of the Bundling Policy as discussed *infra*.

Plaintiffs also plausibly allege that UBH breached its duties. As for the duty to administer the Plans with “care, skill, prudence, and diligence,” Plaintiffs claim UBH breached it by deliberately designing the Guidelines to implement the Plans’ GASC Requirement in more restrictive ways than the actual GASC required. As for the duty of loyalty, the alleged breach is that UBH designed these overly restrictive Guidelines and the Bundling Policy to avoid providing benefits to the Plan members, putting its own financial self-interest above its beneficiaries. Defendants’ arguments on this front reduce to the same ones it presents as to the individual wrongful denial claims, discussed *infra*, and they fail for the same reasons. At this stage, Plaintiffs plausibly allege fiduciary duty breaches based on Defendant’s development and use of the Guidelines and the Bundling Policy.

B. Wrongful Denial Claim as to GASC

Plaintiffs claim under 29 U.S.C. § 1132(a)(1)(B) is that UBH, as an ERISA plan administrator “abused its discretion” by “constru[ing] provisions of the plan in a way that conflicts with the plain language of the plan.” *See Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 458 (9th Cir. 1996) (internal quotation marks and citation omitted). To state that claim properly, Plaintiffs must “allege both (1) the existence of an ERISA plan and [] identify (2) the provision under the plan that entitle them to benefits.” *Kazda*

1 v. *Aetna Life Ins. Co.*, No. 19-cv-02512-WHO, 2019 WL 11769104, at *2 (N.D. Cal. 2019). Here,
 2 Plaintiffs have done both. *See, e.g.*, AC ¶ 5 (alleging the existence of a Plan), ¶¶ 26–37
 3 (identifying terms in the Plan), ¶ 41 (identifying the GASC that the Plan terms reference), ¶ 215
 4 (averring denial based on the Guidelines that allegedly misconstrue the GASC that they
 5 purportedly implement).

6 Defendant argues that Plaintiffs fail to state a claim because, in its view, they must allege
 7 that “UBH’s alleged error in utilizing the Guidelines . . . prejudic[ed] them” in some concrete way.
 8 *See* Mot., Dkt. No. 78 at 14 (quoting *Wit*, 79 F.4th at 1086). *Wit* found that the district court
 9 “erred in granting class certification here based on its determination that the class members were
 10 entitled to have their claims reprocessed regardless of the individual circumstances at issue in their
 11 claims.” 79 F.4th at 1084. Whether the *Wit* Plaintiffs had plausibly stated a claim was not at issue
 12 in that appeal, so the cited language is inapposite at the motion to dismiss stage.

13 At any rate, Plaintiffs *do* plausibly allege that UBH denied their claims “based on the
 14 wrong standard *and* that [they] might be entitled to benefits under the proper standard,” the two
 15 prongs of the *Wit* standard for securing (not *pleading*) reprocessing relief. *Id.* First, Plaintiffs
 16 allege that each of their Plans provided coverage for residential treatment of behavioral health
 17 conditions subject to those Plans’ GASC Requirement. *See, e.g.*, AC at ¶ 27, 32–37. They also
 18 allege that UBH used its Guidelines to implement those GASC requirements. *See e.g., id.* ¶ 3.
 19 The crux of their complaint is the way the Guidelines allegedly distort the GASC that they purport
 20 to implement, making them excessively narrow such that claims are denied more often. *Id.*
 21 ¶¶ 49–55 (describing the *Wit* trial court’s findings of fact). Finally, Plaintiffs allege that the only
 22 reason UBH provided for the denials was Plaintiffs failure to satisfy the allegedly too-narrow
 23 Guidelines—not any other component of the medical necessity criteria in their individual Plans.
 24 *See, e.g., id.* ¶ 215 (alleging that the Guidelines were the “exclusive and decisive basis for each
 25 benefit denial at issue in this claim”). Altogether, these aspects of the complaint plausibly allege
 26 that UBH used an arbitrary and capricious standard to deny Plaintiffs’ claims and that they might
 27 be entitled to benefits under a non-distorted interpretation of GASC.

While UBH argues that other reasons than the Guidelines might have motivated the denials, at this stage in the case, Plaintiffs' allegations must be taken as true. Moreover, UBH was required by law and regulation to include all the reasons for a denial in an understandable denial letter. 29 U.S.C. § 1131(1); 29 C.F.R. § 2560.503-1(g) & (l). It is unclear, for example, why UBH highlights that Plaintiff Beach's Plan also excludes coverage for experimental services or custodial care (as that Plan defines those terms). Plaintiff avers that her daughter was admitted for residential treatment of health conditions and received coverage for twelve days only to be denied such coverage from November 19, 2019 onward. In the written denial notice, UBH explained that its determination was "[b]ased on" its "Medical Necessity criteria for Mental Health Residential Treatment Center Level of Care." The letter further explained why her daughter did not meet the Guidelines criteria, noting that she was "doing better," "willing and able to participate in treatment," "has no thoughts of harming self or others" "is able to take care of daily needs," "is medically stable," and "has supportive family." AC ¶ 77. On appeal, UBH affirmed the denial based on the "Mental Health Residential Level of Care" guideline that the requested service apparently did not meet. The stated rationale was "the patient is not at immediate risk of hurting herself or others. She is medically stable. She is not on psychotropic medication. She does not require 24 hour medical or psychiatric care." *Id.* ¶ 80. None of the notices Plaintiff received mentioned the red herring rationales that Defendant raises, so there is no reason at this juncture to conclude they could have motivated the denials. Instead, all the notices cited the Guidelines criteria, and specific descriptions of why she was denied implicate the aspects of GASC that Plaintiff asserts the Guidelines failed to reflect.

Defendant counters with the other components of medical necessity as defined by the Plans at issue. For instance, Plaintiff Beach's Plan apparently provides that services are only "medically necessary" if they are "in accordance with [GASC]" *and* "clinically appropriate," "not mainly for your convenience," and "not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment." Mot. to Dismiss, Dkt. No. 78 at 16 (citing Ex. A, Dkt. No. 78-3, at 137). Because

1 Plaintiff Beach does not allege that her claim for residential treatment satisfies these other
2 requirements of medical necessity, Defendant claims she fails to show she might be entitled to
3 benefits under the proper standard.

4 This framing, however, overlooks Defendant’s legal obligation to put the reasons for a
5 denial in the denial notice—and the alleged fact, taken as true, that Defendant’s notices only
6 provided one reason for denying coverage: The Level of Care Guidelines it developed to
7 implement the Plans’ GASC requirements. If some other component of the medical necessity
8 criteria were the basis for those denials, the notices would have said so. That they allegedly do not
9 is sufficient, at this stage, to sustain the claim.

10 To be sure, Defendant is correct that Plaintiffs do not allege every criterion or provision in
11 the Guidelines was inconsistent with GASC. *Compare* AC ¶ 47 (alleging that the 2018 and 2019
12 LOCGs at issue in this case were “substantially similar” to the LOCGs at issue in *Wit*), with *Wit*,
13 79 F.4th at 1085 (“there are also many provisions of the Level of Care Guidelines that Plaintiffs
14 did not challenge and that the district court did not find to be overly restrictive”). Before the
15 putative class may be certified, Plaintiffs will need to demonstrate that the particular mismatches
16 they allege between GASC and the Guidelines were the basis of their Guidelines-based denials.
17 Defendant’s motion to strike gets at that issue and is discussed *infra*. At the motion to dismiss
18 stage, however, the need to connect the dots between Plaintiffs’ denials and the particular
19 challenges to the Guidelines that they raise is not a basis to deem the allegations implausible. For
20 now, they’ve sufficiently alleged that the Guidelines were overly restrictive and the basis for their
21 denials such that reprocessing under properly interpreted GASC might result in benefits.

22 **C. Wrongful Denial Claim as to Bundling**

23 Plaintiffs’ allegations regarding wrongful denials based on the Bundling Policy likewise
24 suffice to state a claim under 29 U.S.C. § 1132(a)(1)(B). They assert that their individual plans
25 provided coverage for those services and further, that their Bundling Policy-based denials
26 explicitly opined that lesser-included component services that Plaintiffs received as part of their
27 residential treatment were medically necessary and appropriate for each Plaintiff. *See, e.g.*, AC

¶ 79 (“Care could continue at Partial Hospitalization Program,” a level of care that is allegedly subsumed within residential treatment). UBH denied coverage for those component services anyway, Plaintiffs claim, because they came (as UBH’s policy required) in a bundle with other services that UBH deemed unwarranted. Because no Plan term authorizes denial of medically necessary services simply because they are bundled with other services deemed unnecessary, Plaintiffs state a claim.

Defendant argues that cannot be because nothing in the Plans requires coverage of medically necessary services on an unbundled basis when received as part of residential treatment. *See Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204, 1213 (9th Cir. 2020) (“To plead a violation” of 29 U.S.C. § 1132(a)(1)(B), a plaintiff must allege, among other things, “the provisions of the plan that entitle [them] to benefits.”). While this standard is correct, this framing of the case is upside down: Plaintiffs aver that the component services are covered as medically necessary under their Plans and that no Plan provisions exclude or even limit covered services merely because they occurred in a facility setting or in conjunction with other services. Defendant also argues that its Bundling Policy complies with the Plans’ definitions of eligible expenses, but as Plaintiff notes, that argument presents a question of fact not presently before the court. *See Weizman v. Talkspace, Inc.*, No. 23-cv-00912-PCP, 2023 WL 8461173, at *2 (N.D. Cal. 2023) (noting that courts may not consider “competing factual allegations presented by the other party” on a motion to dismiss). At any rate, as Plaintiffs highlight, the eligible expenses provision only addresses *how* UBH calculates the benefits due for an already-approved claim—not whether to approve a claim.

Defendant’s additional argument that Plaintiffs fail to allege harm to their right to benefits resulting from the Bundling Policy fails to merit dismissal. Plaintiffs allege that they received services covered under their Plans, as UBH itself suggested by stating in their denial letters that the services would be appropriate at a lower level of care, but that those services were denied because of the Bundling Policy. In suggesting that Plaintiffs should have urged their facilities to resubmit claims for lesser included services, Defendant fails to account for Plaintiffs’ parallel assertion that the denial letters did not explain how the Bundling Policy was causing the denial nor

1 how to appeal that aspect of the decision. Ultimately, Plaintiffs have “nudged” their improper
2 denial due to the Bundling Policy claim “across the line from conceivable to plausible.” *Twombly*,
3 550 U.S. at 570.

4 **D. Inadequate Notice Claim**

5 Defendant also objects to Plaintiffs’ claim for relief from allegedly deficient notice, which
6 they claim occurred in two ways: when UBH “fail[ed] to disclose in its denial letters . . . that their
7 coverage requests were denied in full pursuant to UBH’s internal [Bundling Policy]” and, second,
8 when it “failed to provide any information on how the Plaintiffs or Class members could perfect
9 their claims for the lesser-included component services” that Plaintiffs contend should have been
10 covered. AC ¶ 231.

11 Most of Defendant’s argument on this claim fails for the same reasons explained as to the
12 Bundling Policy with which it intertwines. At this stage, citation to *Condry v. UnitedHealth Grp.,*
13 *Inc.*, No. 20-16823, 2021 WL 4225536 (9th Cir. 2021) is inapt. That case concerned an appeal
14 from a grant of summary judgment, in which the panel affirmed that the plaintiffs’ plans were not
15 required to cover out-of-network services. *Id.* at *2. Because the plaintiffs lacked even a potential
16 claim to benefits, any favorable ruling about the deficient notices they received would not have
17 redressed any injury—there was none; the claims were legitimately denied. *Id.* at *3. Here, by
18 contrast, Plaintiffs deficient notice claim rests on the Bundling Policy claim that, as just explained,
19 plausibly alleges both an injury and the possibility of redress via reprocessing.

20 Moreover, to the extent Defendant characterizes this claim as concerning a “bare
21 procedural violation,” it misreads Plaintiffs’ operative complaint. They specifically allege that the
22 insufficient notice of the Bundling Policy’s impact on their denials “deprived the Plaintiffs and the
23 Bundled Denial Class members of any opportunity to object to the ‘specific reason’ for the denial,
24 in full, of their requests for coverage and any opportunity to perfect their claims for benefits for
25 the lesser-included services, which should otherwise have been covered under their plans.” AC
26 ¶ 231. At bottom, the motion to dismiss stage concerns only the plausibility of a complaint’s
27 allegations, and Plaintiffs’ allegations suffice to state a claim.

E. Reprocessing Relief

In the alternative, Defendant urges the court to dismiss or strike Plaintiffs' prayers for claim reprocessing, citing the way that *Wit* decertified a reprocessing relief class. *Wit*, however, concerned a differently defined class and a significantly different record, prepared over years of litigation and an extensive bench trial. This case is just getting out of the gates. Whether these Plaintiffs can sufficiently demonstrate that they are entitled to reprocessing, including by showing that the application of the wrong standard could have prejudiced them, is a question that this case may someday answer. Presently, however, Plaintiffs need not demonstrate such entitlement.

V. CONCLUSION

Defendant's motion to dismiss or, in the alternative, strike Plaintiffs' prayer for claim reprocessing, is denied.

IT IS SO ORDERED.

Dated: May 5, 2025


RICHARD SEEBORG
Chief United States District Judge