

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIAMARY JONES, et al.,  
Plaintiffs,

v.

UNITED BEHAVIORAL HEALTH,  
Defendant.

Case No. 19-cv-06999-RS

**ORDER DENYING MOTION TO  
DECERTIFY AND GRANTING  
MOTION TO MODIFY****I. INTRODUCTION**

Plaintiff Mary Jones brought this putative class action through her mother, Sandra Tomlinson, against Defendant United Behavioral Health (“UBH”) to redress alleged ERISA violations. In a prior order, the class was certified pursuant to Rule 23 of the Federal Rules of Civil Procedure. *See Jones v. United Behav. Health*, No. 19-cv-6999-RS, 2021 WL 1318679, at \*1 (N.D. Cal. 2021) (hereafter, “Class Cert. Order”). After that decision, the Ninth Circuit reversed the certification of similar classes in a related litigation involving the same claims, counsel, and defendant at issue here. *See Wit v. United Behav. Health*, 79 F.4th 1068 (9th Cir. 2023). In light of *Wit*, Defendant moves to decertify the class, while Plaintiff moves to modify it. For the reasons explained below, Defendant’s motion is denied, and Plaintiff’s motion is granted.

**II. BACKGROUND****A. This Case**

The prior certification order in this case describes the facts and allegations that it comprises. *See Class Cert. Order*, 2021 WL 1318679, at \*1–2. Lengthy elaboration is, at this

stage, unnecessary; in short, Plaintiff avers that she was a beneficiary of a UBH-administered, ERISA-governed health plan and that she was denied benefits pursuant to UBH's internally developed Level of Care and Coverage Determination Guidelines (respectively ("LOC" and "CD" Guidelines). From June 2, 2017 through February 7, 2018, UBH used its 2017 Guidelines to make discretionary coverage decisions relating to the behavioral health claims of beneficiaries like Plaintiff. As a precondition to coverage, each underlying plan that UBH administered required that the requested treatment comport with generally accepted standards of care ("GASC").

Plaintiff avers that UBH processed her claim in a manner inconsistent with GASC. She claims Defendant "fashioned overly-restrictive criteria, reflecting an excessive emphasis on short-term/crisis-stabilizing services, for mental health and substance abuse coverage determinations; embedded those criteria within the 2017 Guidelines; and, by applying those Guidelines to her claim, violated its duties to her under ERISA." *Id.* at \*2. Like the plaintiffs in *Wit*, Plaintiff argues that the Guidelines UBH relied on to deny her claim failed to account for the following generally accepted patient placement/effective level of care behavioral health standards:

- Effective treatment requires treatment of the individual's underlying conditions and is not limited to alleviation of the individual's current symptoms;
- Effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care;
- Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective;
- When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care;
- Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration;
- The appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment;
- The unique needs of children and adolescents must be taken into account when making

1 level of care decisions involving their treatment for mental health or substance use  
2 disorders;

- 3 • The determination of the appropriate level of care for patients with mental health and/or  
4 substance use disorders should be made on the basis of a multi-dimensional assessment  
5 that takes into account a wide variety of information about the patient.

6 *Id.* (citing Mot. for Class Cert., Dkt. No. 63 at 14–15). The Wit trial court found that all of these  
7 generally accepted standards of care were not effectuated by the pre-2017 Guidelines. *See Wit v.*  
8 *United Behav. Health*, No. 14-cv-2346-JCS, 2019 WL 1033730, at ¶¶ 71–81 (N.D. Cal. 2019)  
9 (“*Wit* FFCL”).

10 Due to the alleged mismatch between the above GASC and the allegedly much narrower  
11 coverage criteria in the 2017 Guidelines, Plaintiff avers that UBH violated ERISA § 1104(a),  
12 which requires fiduciaries such as UBH to discharge their duties “solely in the interest of the  
13 participants and beneficiaries . . . (i) for the exclusive purpose of providing benefits to participants  
14 and their beneficiaries and (ii) defraying reasonable expenses of administering the plan.”  
15 According to Plaintiff, UBH breached its fiduciary duties of loyalty and care by developing its  
16 Guidelines so that claims procedures would favor denials where they should have resulted in  
17 benefits, boosting its bottom line rather than acting solely in the interests of the plan participants  
18 and beneficiaries.

19 Plaintiff also invokes ERISA § 1132(a)(1)(B), which provides a right of action for  
20 participants and beneficiaries “to recover benefits due . . . under the terms of [their] plan [or] to  
21 enforce [their] rights under the terms of the plan.” She avers that UBH’s denials of her requests  
22 and those of other Class members were procedurally arbitrary and capricious because the  
23 Guidelines on which they were based were more restrictive than the GASC that they ostensibly  
24 implemented pursuant to the plans’ terms.

25 As classwide relief, Plaintiff seeks a declaratory judgment that the 2017 Guidelines are  
26 inconsistent with GASC; a permanent injunction to prevent UBH from administering putative  
27 class members’ claims via the 2017 Guidelines; and an order requiring UBH to reprocess class  
28 member claims. This last form of relief “is the correct course to follow when an ERISA plan

1 administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong  
 2 standard to a benefits determination.” *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term*  
 3 *Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996).

4 More than four years ago, Plaintiff’s putative class was certified based on the following  
 5 class definition:

6 Any participant or beneficiary in a health benefit plan governed by ERISA whose  
 7 request for coverage of residential treatment services for a mental illness or  
 8 substance use disorder was denied by UBH, in whole or in part, on or after June 2,  
 9 2017, based upon UBH’s 2017 Level of Care Guidelines (“LOCs”) or upon a  
 Coverage Determination Guideline that incorporates the 2017 LOCs, and whose  
 request was not subsequently approved, in full, following an administrative appeal.

10 Class Cert. Order, 2021 WL 1318679, at \*3. The Court appointed Mary Jones as the Class  
 11 Representative and the law firms Zuckerman Spaeder LLP and Psych-Appeal Inc. as co-lead class  
 12 counsel. *Id.* at \*9.

### 13 **B. *Wit* Litigation**

14 Since the class in this case was certified, the Ninth Circuit’s *Wit* opinion has “clarified the  
 15 guidelines for evaluating similar classes for certification based on reprocessing remedies.” *Kazda*  
 16 *v. Aetna Life Ins. Co.*, No. 19-cv-02512-WHO, 2023 WL 7305038, at \*7–8 (N.D. Cal. Nov. 6,  
 17 2023). Notably, the *Wit* decision preserved certification of a class with respect to the same breach  
 18 of fiduciary duty claim averred in this case. 79 F.4th at 1084 n.5; *see also id.* at 1089 (“the district  
 19 court did not err in certifying three classes to pursue the fiduciary duty claim”).<sup>1</sup>

20 As to the *Wit* class’s denial of benefits claim, however, the panel found error in the lower  
 21 court’s “determination that the class members were entitled to have their claims reprocessed  
 22 regardless of the individual circumstances at issue in their claims.” *Id.* at 1084. To be entitled to a  
 23 reprocessing remedy for an arbitrary and capricious denial of benefits under an ERISA plan, the  
 24

25 \_\_\_\_\_  
 26 <sup>1</sup> This case literally picks up where *Wit* left off: Plaintiff sued after the trial in *Wit*, asserting  
 27 essentially identical claims but as to denials that occurred between June 2, 2017 (when the *Wit*  
 class period ended), and February 7, 2018, when UBH ceased using the 2017 LOC Guidelines at  
 issue. See Dkt. No. 63, Class Cert. Mot. at 2.

1 panel explained, a plaintiff must show that “his or her claim was denied based on the wrong  
2 standard *and* that he or she might be entitled to benefits under the proper standard.” *Id.* (citing  
3 *Saffle*, 85 F.3d at 461). In the next sentence, the Wit panel characterizes that requirement as  
4 “showing that application of the wrong standard could have prejudiced the claimant.” *Id.* “This  
5 language establishes a floor below which claimants seeking to certify a class based on  
6 reprocessing as a remedy may not fall; the floor is a showing of possible prejudice.” *Kazda*, 2023  
7 WL 7305038, at \*8.

8 The *Wit* trial court had determined that UBH’s LOC Guidelines amounted to its  
9 interpretation of GASC but that many provisions of those Guidelines were more restrictive than  
10 necessary—findings of fact that UBH did not challenge on appeal. *Wit*, 79 F.4th at 1085.  
11 “[B]ecause the Guidelines were ‘significantly and pervasively more restrictive than’ GASC in  
12 eight specific ways,” the trial court reasoned, “‘every adverse benefit determination made by UBH  
13 based in whole or in part on any of the Guidelines . . . was wrongful and made in violation of plan  
14 terms and ERISA.’” *Id.* The Ninth Circuit, however, highlighted that the *Wit* plaintiffs had not  
15 challenged all the provisions of the LOC Guidelines and that, as a result, the trial court had no  
16 occasion to deem every single one of its sections overly restrictive. Similarly, some of the CD  
17 Guidelines went unchallenged—and some only incorporated the LOC Guidelines as support in a  
18 particular paragraph—so there “[wa]s no indication that a claimant whose claim was denied under  
19 one of the many unchallenged provisions in the [CD] Guidelines failed to receive a full and fair  
20 review of his or her claim.” *Id.* In other words, not every class member’s adverse benefit  
21 determination resulted from one of the specific applications of the overly restrictive Guidelines  
22 that the trial court identified; some claimants “were denied coverage solely based on unchallenged  
23 provisions,” while others were denied only “in part” based on the Guidelines. *Id.* Because  
24 remand for reevaluation might be a “useless formality” for such class members, certification had  
25 wrongly enlarged or modified their substantive ERISA rights, a violation of the Rules Enabling  
26 Act. *Id.* at 1086 (citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 367 (2011) (quoting 28  
U.S.C. § 2072(b))).

27 On remand, the district court resisted the suggestion that it enter judgment in favor of UBH  
28

as to the denial of benefits claim. *Wit v. United Behav. Health*, No. 14-cv-02346-JCS, 2023 WL 8717488, at \*25–26 (N.D. Cal. Dec. 18, 2023). UBH petitioned for mandamus, which the Ninth Circuit subsequently granted. *See United Behav. Health v. United States Dist. Ct. for N. Dist. of California*, No. 24-242, 2024 WL 4036574, at \*1 (9th Cir. Sept. 4, 2024) (directing the district court to enter judgment for UBH on the denial of benefits of claim). The panel reiterated its prior holding, explaining that the class was erroneously certified because it was not “limited to claimants whose claims were denied based only on UBH’s challenged Guidelines.” *Id.*

In light of *Wit*, Defendant moves to decertify the class, and Plaintiff moves to modify it.

### III. LEGAL STANDARDS

#### A. Class Decertification

Rule 23 of the Federal Rules of Civil Procedure governs class actions like this one. Under Rule 23(c)(1)(C), a court may decertify a class at any time before final judgment. *See Rodriguez v. W. Publ’g Corp.*, 563 F.3d 948, 966 (9th Cir. 2009). The Rule 23 legal standard that guides class certification also guides class decertification. *Ries v. Arizona Bev. USA LLC*, No. 10-cv-01139-RS, 2013 WL 1287416, at \*3 (N.D. Cal. March 28, 2013); *see also Marlo v. United Parcel Serv., Inc.*, 639 F.3d 942, 947 (9th Cir. 2011). A motion for decertification will generally only succeed where there has been some change in the law or facts that justifies reversing the initial certification decision. *See In re Myford Touch Consumer Litig.*, No. 13-cv-03072-EMC, 2018 WL 3646895, at \*1 (N.D. Cal. Aug. 1, 2018).

A plaintiff seeking to prevent class decertification bears the burden of satisfying four requirements set forth in Rule 23(a) and at least one of the requirements set out in Rule 23(b). *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013). Where the certification hinges on Rule 23(b)(3), as it does here, a plaintiff must specifically establish that common questions predominate over questions affecting only individual class members and that class action adjudication is superior to other resolution methods. “The predominance inquiry asks whether the common, aggregation-enabling, issues in the case are more prevalent or important than the non-common, aggregation-defeating, individual issues.” *Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 453 (2016) (internal citation omitted). A plaintiff must make this predominance showing by a

preponderance of the evidence. *Olean Wholesale Grocery Cooperative, Inc. v. Bumble Bee Foods LLC*, 31 F.4th 651, 664 (9th Cir. 2022) (en banc). Such common questions need only be capable of class-wide resolution; plaintiffs are not required to show that “the evidence in fact establishes [they] would win at trial.” *Id.* at 667.

### B. Class Modification

The ability to decertify a class is but one example of a “district court[‘s] . . . flexibility to address problems with a certified class as they arise.” *United Steel, Paper & Forestry, Rubber, Mfg. Energy, Allied Indus. & Serv. Workers Int’l Union, AFL-CIO, CLC v. ConocoPhillips Co.*, 593 F.3d 802, 809 (9th Cir. 2010). Another is the ability to modify the class definition, which a judge is free to do “[e]ven after a certification order is entered . . . in the light of subsequent developments in the litigation.” *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 160 (1982); *see also* Fed. R. Civ. P. 23(c)(1)(C) (“An order that grants or denies class certification may be altered or amended before final judgment.”). When a district court “revisit[s] a class certification order . . . any amendment thereto must satisfy the requirements of Rule 23.” *Heredia v. Eddie Bauer LLC*, 2020 WL 127489, at \*3–4 (N.D. Cal. Jan. 10, 2020) (internal quotations omitted).

## IV. DISCUSSION

On at least one thing, the parties agree—the class certification order in this case must change in light of *Wit*. Plaintiffs concede that, as currently defined, the class contains at least some members who would likely not be entitled to a reprocessing remedy; for example, some did not receive the services for which coverage was sought and therefore did not incur any expenses—meaning they would be ineligible for the initially sought-after benefits even if the claim were reprocessed under more fairly-designed Guidelines. *See* Mot. to Modify, Dkt. No. 99-3 at 11. Other claim denials may have rested on reasons distinct from the 2017 LOC or CD Guidelines or been based on some component of those Guidelines that the Plaintiffs’ have not challenged or that the *Wit* trial court did not identify as an overly restrictive implementation of GASC.

To cleave away these members for whom reprocessing would be a useless formality, Plaintiff proposes modifying the class certification order pursuant to Fed. R. Civ. P. 23(c)(5) so

that reprocessing relief is only available to:

Any member of the 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 2017 LOCGs or a Coverage Determination Guideline that incorporates the 2017 LOCGs, and/or (b) specifies that the member's failure to satisfy the applicable Guideline was based solely on a portion of the applicable Guideline that was unchallenged in this action.

Motion to Modify, Dkt. No. 99-3 at 14.

In Plaintiff's view, this subclass would appropriately ensure that reprocessing is available as a potential remedy to only those members who paid for treatments that UBH didn't cover because of the challenged Guidelines. Determining membership in this class will hinge on UBH's claim denial letters, which Congress has dictated must "set[] forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1131(1). By regulation, the notice must refer to the "Specific plan provisions" or "rule, guidelines, protocol, or other similar criterion" on which denial is based, as well as explain the "clinical judgment for the determination." 29 C.F.R. § 2560.503-1(g)(1). During the *Wit* trial, UBH's corporate designee also testified that "[a]s a matter of UBH policy, UBH's denial letters must summarize *all* the reasons for denial." See FFCL, 2019 WL 1033730, at \*13. Because the letters necessarily contain all the bases for each putative subclass members' denial, Plaintiff argues that the class will be objectively ascertainable. So long as the letter does not reference an unchallenged Guideline, she says, it must rest on a challenged Guideline.

Defendant, on the other hand, urges the court to decertify the class and to refrain from modification. UBH highlights that, as the class is currently defined, Plaintiff cannot make the requisite showing on a class-wide basis that all class members were denied benefits because of the application of a challenged portion of the 2017 LOC Guidelines. The prior order in this case

1 conditioned certification on the fact that the equitable reprocessing relief Plaintiff sought required  
 2 showing only that “but for the application of the 2017 Guidelines, coverage requests would have  
 3 been processed in an ERISA-compliant manner.” Class Cert. Order, 2021 WL 1318679, at \*8.  
 4 Post *Wit*, it is now clear that Plaintiff must show that “his or her claim was denied based on the  
 5 wrong standard *and* that he or she might be entitled to benefits under the proper standard.” 79  
 6 F.4th at 1084. Defendant also notes that, because Plaintiff seeks reprocessing relief via her breach  
 7 of fiduciary duty claim as well as her denial of benefits claim, the flaws in the certification of the  
 8 latter also infect the certification of the former.  
 9

10 Because Plaintiff’s modification proposal satisfies the Rule 23(a) and (b) requirements for  
 11 class actions as explained below, as well as the two-part *Wit* standard, her motion to modify the  
 12 class is granted, and Defendant’s motion to decertify the class is denied.

### 13 **A. Rule 23(a)**

#### 14 **1. Numerosity (Rule 23(a)(1))**

15 A class should be certified where the “class is so numerous that joinder of all members is  
 16 impracticable.” Fed. R. Civ. P. 23(a)(1). “While there is no fixed number that satisfies the  
 17 numerosity requirement, generally, a class greater than forty is sufficient while one less than  
 18 twenty-one is not.” *Gold v. Lumber Liquidators, Inc.*, 323 F.R.D. 280, 287 (N.D. Cal. 2017).  
 19 Plaintiff’s counsel has identified 38 people within the 60-person Claim Sample who likely qualify  
 20 for membership in the proposed Reprocessing Subclass. *See* Ex. 10, Dkt. No. 135-7 (Chart  
 21 entitled, “Claim Sample Members Who Meet Class and Subclass Criteria”); *see also* Ex. 7, Dkt.  
 22 No. 136-7 (July 2020 joint stipulation regarding claim sample construction). Counsel represents  
 23 that the 60-person sample is a subset of a 3,700-person pool. Defendant does not contest the  
 24 numerosity showing. Numerosity is therefore satisfied.  
 25  
 26

#### 27 **2. Commonality (Rule 23(a)(2))**

Commonality is met when “the class members’ claims ‘depend upon a common contention’ such that ‘determination of its truth or falsity will resolve an issue that is central to the validity of each claim in one stroke.’” *Gold*, 323 F.R.D. at 287 (quoting *Mazza v. Am. Honda Motor Co.*, 666 F.3d 581, 588 (9th Cir. 2012)). “[C]ommonality only requires a single significant question of law or fact.” *Mazza*, 666 F.3d at 589; *see also Gold*, 323 F.R.D. at 287. The prior order in this case determined that commonality existed because “scrutiny of a single policy (The 2017 Guidelines), as applied to a single aspect of every class member’s plan (the [GASC] provision), under a single statutory framework (ERISA), will ‘generate common answers apt to drive the resolution of the litigation’.” Class Cert. Order, 2021 WL 1318679, at \*5.

In arguing to decertify the existing class, UBH argues that the *Wit* ruling requires Plaintiff to show that each individual class member was denied benefits based exclusively on an actually-challenged provision of the 2017 LOCGs; that there was no alternative, legitimate basis given for the class member’s denial; and that application of the “proper” guidelines, rather than the 2017 LOCGs, might have resulted in the payment of benefits. UBH Reply Br., Dkt. No. 109 at 10 (citing *Wit*, 79 F.4th at 1083–86). Plaintiff’s proposed modification largely accounts for these parameters: it carves out reprocessing as something available to only those class members who paid for services and received claim denial notices that rest on a challenged aspect of the 2017 LOC Guidelines. Moreover, they all would be eligible for repayment under the proper guidelines, given that they suffered monetary harms and considering that the challenged guidelines are, by definition, the cause of their denials. To the extent that the class definition includes some members whose denials cite challenged *and* unchallenged aspects of the Guidelines (given that it only excludes members whose letters cite an unchallenged aspect of the Guidelines as the “sole” reasons for denial), Plaintiff notes it accords with *Wit*’s critique of the class definition in that case—that it included claimants “who were denied coverage solely based on unchallenged

provisions of these Guidelines.” 79 F.4th at 1085.

Opposing Plaintiff’s proposal, UBH complains that identifying the reason for each individual denial will require a detailed, clinical analysis of each class member’s coverage decision letter, claim history, and other records—an expansive and individualized inquiry that it says defeats commonality. Although the Ninth Circuit has held, in an unpublished memorandum, that “courts must consider the entire course of communication between the plan administrator and the plan participant to determine whether the denial letter provided a sufficiently clear reason for the denial,” see *Condry v. UnitedHealth Grp., Inc.*, No. 20-16823, 2021 WL 4225536, at \*4 (9th Cir. Sept. 16, 2021), that case concerned a 29 U.S.C. § 1133 claim that denial notices were insufficiently clear. Here, there is no such claim; the question is whether the denial notices rested on allegedly non-GASC compliant Guidelines, in contravention of Plan terms and UBH’s fiduciary duties. Indeed, Plaintiff suggests that the court *rely* on the denials as the *clearest* expression of why claims were denied to confirm that those claimants experienced the asserted harm.

Moreover, as required by statute and found by the *Wit* court, UBH included all reasons for a denial in each notice. Together, these two aspects of the case mean that a detailed search of the administrative record is an overbroad method of answering a far simpler question than that which the *Condry* court confronted (*i.e.*, whether Section 1133 was violated by insufficiently clear communications). Denial letters in which UBH was legally and internally required to explain fully its reasoning are sufficient for the limited purpose of confirming that a class member experienced the harm caused by the alleged common issue: that UBH’s denials violated plan terms by relying on the Guidelines’ overly restrictive interpretation of the Plans’ GASC requirements. In this regard, the case contains common contentions “of such a nature that it is capable of classwide resolution” and “will resolve an issue that is central to the validity of each one of the claims in one stroke.” See *Dukes*, 564 U.S. at 350. “What matters to class certification” is “the capacity of a

class-wide proceeding to generate common answers apt to drive the resolution of the litigation.”

*Id.*

Defendant’s citation to *Bain v. Oxford Health Insurance Inc.*, No. 15-cv-3305-EMC, 2020 WL 808236, at \*9 (N.D. Cal. Feb. 14, 2020) underscores its inapplicability: the referenced discussion concerns whether the *Wit* trial court’s rulings had preclusive effect as to UBH’s liability against the *Bain* plaintiffs on a bid for an award of benefits (not one for reprocessing). To distinguish the *Wit* case, the *Bain* court highlighted the degree to which the relevant plaintiffs had not shown that their communications directly referenced the Guidelines at issue in *Wit*. *See id.* at \*9 (noting that it was “hard to point to any specific deficiency in the Guidelines that impacted the instant case”). The fact that the *Bain* plaintiffs’ denial letters did not “quote specific parts of or otherwise refer to specific provisions” in the Guidelines was cause to steer clear from applying collateral estoppel to preclude UBH from contesting liability, *id.*, but in no respect did the *Bain* court consider whether the letters could have been used to demonstrate membership in a claims reprocessing class.<sup>2</sup> Indeed, even after scouring the entire record, the *Bain* court determined that it could not discern outright whether to award the benefits and opted to award reprocessing instead.

Considering all the above, the proposed Subclass satisfies 23(a)(2)’s commonality requirement. It remains the case that scrutinizing the 2017 Guidelines as applied to the same GASC provision of every class member’s plan pursuant to the same ERISA statutory framework

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<sup>2</sup> In arguing that the letters are insufficient grounds by which to determine whether a denial occurred due to a challenged implementation of the guidelines, UBH wanders into a quagmire. Why is it “not enough” that Plaintiff’s denial letter is devoid of any reference to an unchallenged criterion? *See* UBH Opp Br., Dkt. No. 110-3 at 22. By law, the letter must “set[] forth the specific reasons for such denial, written in a manner calculated to be understood by the participant.” 29 U.S.C. § 1131(1). UBH’s own executive testified that the letters always contained the reasons for denial. It cannot be the case that UBH included all the reasons for denial in the letters *and* that the letters might be missing references to unchallenged reasons that nevertheless motivated a denial.

“will ‘generate common answers apt to drive the resolution of the litigation.’” Class Cert. Order, 2021 WL 1318679, at \*5.

### 3. Typicality (Rule 23(a)(3))

Rule 23(a)(3) requires that “the claims or defenses of the representative parties are typical of the claims or defenses of the class.” Typicality ‘aims at ensuring that plaintiffs are proper parties to proceed with the suit.’ *Gold*, 323 F.R.D. at 288. “The test is ‘whether other members have the same or similar injury, whether the action is based on conduct which is not unique to the named plaintiffs, and whether other class members have been injured by the same course of conduct.’” *Id.* (quoting *Gen. Tel. Co. of Sw.*, 457 U.S. at 157–58 n.13).

Plaintiff exemplifies the sort of class member who fits into her proposed subclass. She paid for nearly a year of residential treatment services for which UBH denied coverage. Her initial denial letter and appeal denial letters cite the LOC “Guideline for Mental Health Residential Treatment Center Level of Care,” and the appeal denial letter also cites the “Common Criteria and Clinical Best Practices for all levels of care.” Dkt. 126-5 at 2.

In the clinical reasoning section, UBH described Plaintiff’s multiple co-occurring diagnoses and cited the following reasons for denial: (1) “You have made progress,” (2) “You are no longer endangering the welfare of yourself or others,” (3) “You are able to understand and participate in your care,” (4) “You are medication adherent,” (5) “You do not appear to require 24 hour nursing supervision for your remaining symptoms” and (6) “[You] can continue your recovery in a less restrictive setting.” Dkt. 126-7 at 2. Each of these clinical reasons demonstrate the degree to which the Guidelines that informed them allegedly do not align with GASC. Reasons (2), (3), and (5), according to Plaintiff, show how the guidelines neglected the GASC that “effective treatment requires treatment of the individual’s underlying conditions and is not limited to alleviation of the individual’s current symptoms.” *Compare id. with* Complaint at 2; *see also*

1 *Wit* FFCL, 2019 WL 1033730, at \*17 (“it is generally accepted in the behavioral health  
2 community that effective treatment of individuals with mental health or substance use disorders is  
3 not *limited* to the alleviation of the current symptoms.”). Reasons (1) and (4) implicate the GASC  
4 that “effective treatment of mental health and substance use disorders includes services needed to  
5 maintain functioning or prevent deterioration,” *see* Complaint at 2, while Reason (6) implicates  
6 the GASC that “when there is ambiguity as to the appropriate level of care, the practitioner should  
7 err on the side of caution by placing the patient in a higher level of care.” *Id.* Plaintiff’s complaint  
8 is that the gap between the application of the Guidelines and GASC derived from fiduciary duty  
9 breaches and caused arbitrary and capricious claim denials.<sup>3</sup> That her denial letter can be  
10 connected to specific mismatches between the two demonstrates that she is a typical representative  
11 of others whose denial letters link up to the same group of mismatches.  
12

13 Defendant once again resorts to *Condry*, where the Ninth Circuit reversed the certification  
14 of a claims reprocessing class that revolved around a Section 1133 claim of insufficiently clear  
15 notice. Setting aside that such a claim is not present here, the *Condry* court’s concern with  
16 reliance on the letters was rooted in the individualized nature of each letter’s communications—  
17 communications which went to the heart of the claimed lack of clarity. Here, the letters serve to  
18 confirm only that a member’s claim was denied because of a challenged guideline; at that point,  
19 the claim hinges on common questions for which Plaintiff is a typical representative.  
20

21 Because Plaintiff’s claim denial stemmed from a section of the Guidelines relevant to  
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24 <sup>3</sup> In addition to the alleged mismatches between the Guidelines and GASC, Plaintiff also argues  
25 that the Guidelines *lack* language required by GASC, such as criteria requiring consideration of  
26 the unique treatment needs of children and adolescents or consideration whether the requested  
27 level of care is needed to ensure effective treatment of co-occurring conditions. The *Wit* trial court  
28 agreed that these omissions combined with the Guidelines’ affirmative defects to narrow  
improperly the scope of covered residential treatment services. *Wit* FFCL, 2019 WL 1033730, at  
\*22, 48, 55 (¶¶ 82, 183, 212).

1 mental health conditions, Defendant also contends that she fails typicality to the extent that other  
2 class member claims denials rested on Guidelines relevant to substance use or on CD Guidelines  
3 that never applied to her. This argument misconstrues the proposed subclass. What matters is  
4 whether a denial occurred via the process that Plaintiff alleges was arbitrary and capricious—*i.e.*,  
5 via the application of the challenged Guidelines. The nature of that challenge concerns the  
6 disconnect between those Guidelines and GASC, as well as the alleged fiduciary duty breaches  
7 that caused UBH to develop the Guidelines in a non-GASC compliant manner. These are the  
8 typical issues in the subclass; whether the denied service concerned substance abuse or mental  
9 health treatment is tangential to the ultimate liability questions at stake.

#### 11 4. Adequacy (Rule 23(a)(4))

12 A representative party must be able to “fairly and adequately protect the interests of the  
13 class.” Fed. R. Civ. P. 23(a)(4). UBH highlights that Plaintiff is no longer a member of a UBH-  
14 administered benefits plan, suggesting that she will not benefit from certain aspects of her sought  
15 after relief (*i.e.*, declaratory judgment and a prospective injunction requiring UBH to discontinue  
16 use of the 2017 Guidelines). Moreover, UBH discontinued use of the 2017 Guidelines and has  
17 been using Plaintiff’s preferred guidelines for some time now.

19 While these points helpfully highlight that this case is ultimately about the reprocessing  
20 relief, they do not suggest Jones is an inadequate representative. To the contrary, her interest in  
21 having her denied claim reprocessed situates her squarely among the other class members who  
22 share that goal and who also share her lack of any interest in any declaration and injunction about  
23 no longer using the 2017 Guidelines that UBH no longer uses. Sure, her particular lack of interest  
24 stems in part from her having left the world of UBH administered plans. Yet, it also stems from  
25 the apparent mootness of that relief, which her fellow class members also surely recognize. There  
26 is no indication she will not pursue the case vigorously on behalf of the class to obtain the relief  
27

that motivates them all—that is, the reprocessing of their denied claims.

## **B. Rule 23(b)(3)**

The prior order in this case certified the class under Rule 23(b)(1), (2), and (3). *See* Class Cert. Order, at \*7-9. In moving to modify the class, Plaintiff only cites Rule 23(b)(3) for support.

Certification under Rule 23(b)(3) is proper where the trial court “finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy.” Fed. R. Civ. P. 23(b)(3). Rule 23(b)(3)’s predominance analysis “presumes that the existence of common issues of fact or law have been established pursuant to” Rule 23(a)’s commonality requirement, *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1022 (9th Cir. 1998), *overruled on other grounds by Dukes*, 564 U.S. at 338; and from that starting point, tests “the balance between individual and common issues.” *Wang v. Chinese Daily News, Inc.*, 737 F.3d 538, 546 (9th Cir. 2013) (internal quotation marks and citation omitted). Rule 23(b)(3)’s superiority component, by contrast, asks if a class-wide proceeding “is the most efficient and effective means of resolving the controversy.” *Wolin v. Jaguar Land Rover North America, LLC*, 617 F.3d 1168, 1175 (9th Cir. 2010) (internal quotation marks and citation omitted).

### **1. Predominance**

Common questions predominate over individual questions in the context of the Subclass’s procedural claim and reprocessing request. As discussed *supra*, this case is about whether UBH (1) violated its fiduciary duties by designing overly restrictive Guidelines that did not reflect GASC as required by plan terms and then (2) arbitrarily and capriciously denied benefits claims by using the overly restrictive Guidelines. As the Ninth Circuit has now clarified, Plaintiff’s bid for reprocessing hinges on whether she can show that “her claim was denied based on the wrong

standard and that [she] might be entitled to benefits under the proper standard.” *Wit*, 79 F.4th at 1084. This court’s prior order rightly recognized that the first question is a common one, *See* Class Cert. Order, 2021 WL 1318679, at \*8, so the issue now is determining if the second question—whether each plaintiff can show he or she might be entitled to benefits under Guidelines that do not reflect the mismatches that Plaintiff identified in her complaint—is likewise common.

The answer is yes: all Class members who meet the Subclass criteria incurred unreimbursed expenses that UBH refused to cover based at least in part on its challenged Guidelines, and all members intend to demonstrate that they might have been entitled to benefits under GASC-compliant standards. To be sure, each will have to prove membership by establishing that he or she incurred unreimbursed expenses and received a denial letter that did not solely provide an unchallenged rationale. Such individualized inquiry, however, is not uncommon in class action claims processing—indeed, “Rule 23 specifically contemplates the need for such individualized claim determinations after a finding of liability.” *Briseno v. ConAgra Foods, Inc.*, 844 F.3d 1121, 1131 (9th Cir. 2017). Reliance on “claim administrators, various auditing process, sampling for fraud detection, follow-up notices to explain the claims process, and other techniques tailored by the parties and the court” are routine. *Id.* In this regard, the fact that Plaintiff’s theory of the case requires analysis of Subclass members’ letters hardly amounts to something that predominates over the classwide questions that Plaintiff expects to answer with common proof (*i.e.*, did the Guidelines fail to capture the GASC that they purported to implement, and did UBH violate its fiduciary duties in designing them).

UBH mounts several arguments against finding that common questions predominate, but none persuade.

#### **a. Exhaustion**

One UBH argument concerns the issue of exhaustion. “As a general rule, exhaustion is not required for statutory claims” like breach of fiduciary duty. *See Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1294 (9th Cir. 2014). Although exhaustion may be required where a claim is a “disguised” claim for benefits, the breach of fiduciary duty claim in this case is not an example of “attach[ing] a statutory violation sticker to his or her [denial of benefits] claim and then . . . us[ing] that label as an asserted justification for failure to exhaust.” *Id.* (quotation marks omitted). Here, Plaintiff alleges that the violations were willful and systematic, which means the claim is “not a ‘disguised’ claim for benefits such that exhaustion is required. *Id.* As for the arbitrary and capricious denial of benefits claim, the Ninth Circuit has held that “when an employee benefits plan fails to establish or follow ‘reasonable claims procedures’ consistent with the requirements of ERISA, a claimant need not exhaust because his claims will be deemed exhausted.” *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1088–89 (9th Cir. 2012). Failure to follow reasonable procedures consistent with ERISA is precisely what Plaintiff’s second claim is all about.

Moreover, stepping back from the intricacies of exhaustion, it bears mention that determining exhaustion’s application to these claims involves common legal questions. The exhaustion requirement arises, not from ERISA itself, but rather via the adoption of a prudential exhaustion requirement. *See Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008). “Futility, inadequate remedies, and unreasonable claims procedures each excuse exhaustion,” *Jackson v. Guardian Life Ins. Co. of Am.*, No. 22-cv-3142-JSC, 2023 WL 2960290, at \*3 (N.D. Cal. Apr. 13, 2023) (citing *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980)), and each of those arguments can be made on a classwide basis in this case.<sup>4</sup>

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<sup>4</sup> Although not in its papers, UBH contended at oral argument that assignments could be another reason why individual issues may predominate over common ones in this case. Determining who

## b. Challenged Guidelines

As it does throughout its briefing, UBH bemoans the individualized issues it foresees with Plaintiff's proposed use of the denial letters to determine class membership. Defendant envisions problems because the process will require thousands of individual determinations and line-by-line analysis of denial letters to confirm that they cite only challenged Guidelines for justification.

Plaintiff aptly explains why this argument runs astray. First, UBH only uses the challenged Guidelines when conducting clinical reviews on coverage requests that already met all administrative criteria for coverage. *See, e.g., Wit* FFCL, 2019 WL 1033730, at \*12 (¶¶ 48–49). As a result, any denial letter that references the Guidelines *at all* necessarily did not rest on any administrative reasons unchallenged in this case. Indeed, all but two of the Sample Class Members' denial letters state that their denial was based on UBH's Guidelines and do not identify any non-Guideline basis for denial. *See* Ex. 6, Dkt. No. 126-5 (sealed). The two outliers both appealed and were told that denial was based on the Guidelines. *Id.* at 13-14.

Second, because the claim targets only clinical denials of coverage for residential treatments based on the grounds that treatment is not medically necessary or appropriate, the universe of unchallenged Guidelines that could possibly support a class member's denial is vanishingly small. For example, Plaintiff does not challenge the "Clinical Best Practices" sections, but those sections do not contain any coverage criteria and therefore could not be the basis of a denial. *See also* Ex. 13, Dkt. No. 100-14 (excerpting testimony from the *Wit* trial in which a UBH corporate designee stated that UBH does not base denials on that section). Other unchallenged sections, such as the Introduction to the Guidelines and the References and

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redeems the claim, however, is not a part of the liability inquiry here. If some class members assigned their claims, whoever they were assigned to will have the opportunity to cash them in if liability is found; that is not a reason to deny class certification at this juncture.

History/Revision Information subsections, likewise do not provide coverage criteria and thus do not pose a threat of having formed the basis of a denial.

Plaintiff also leaves unchallenged the Guidelines' experimental services sections; although these might have formed the basis of a denial, such denials feature a distinct denial reason code from the ones used to determine class membership. By stipulation, the claim sample in this case derives from denials in the class period for which UBH's "denial type" was either "Medical Necessity Criteria Not Met," "Clinical Coverage Determination," or "Lack of Active and Progressive Treatment." *See* Jt. Stip. Concerning Sampling Methodology, Ex. B. to Class Cert. Mot., Dkt. No. 64-2 ¶ 2. Plaintiff provides sworn testimony from the *Wit* litigation in which a UBH employee testified that those denial types are the ones UBH used to indicate a Guideline-based denial. *See, e.g.*, Ex. 5-A, Dkt. No. 127-5. Moreover, because residential treatment is not experimental or investigational, *see Wit* FFCL, 2019 WL 1033730, at \*16 (¶ 63), it is unlikely that UBH would have cited the Guidelines' experimental services section in denying a Subclass member's benefits claim.

To aid the court's analysis of which Guidelines are challenged, Plaintiff has identified the unchallenged portions of the 2017 LOC Guidelines that could possibly support a denial. *See* Ex. 4, Dkt. No. 100-4 (collecting "Unchallenged Clinical Coverage Criteria in UBH's 2017 LOCs"). Plaintiff also provided an excerpt from the 2017 Guidelines that omits all extraneous sections (*e.g.*, introductions to sections) and leaves visible only the clinical coverage criteria on which a Class member's denial could possibly have been based. *See* Ex. 2, Dkt No. 100-2. During the *Wit* litigation, the plaintiffs submitted a consolidated claims chart in which they specifically challenged individual Guidelines criteria, and the trial court found each challenged criterion to be inconsistent

1 with GASC.<sup>5</sup> Here, Plaintiff connects those individually challenged Guidelines from the *Wit*  
 2 litigation to the ones in Exhibit 2, establishing that she challenges nearly all of the guidelines on  
 3 which a denial could be based.<sup>6</sup>

4 As for the CD Guidelines, Plaintiff explains how she only challenges those that  
 5 incorporated the challenged LOC Guidelines. The one CD Guideline-based denial letter in the  
 6 claim sample does not state that it is based on any unchallenged CD Guideline criteria; to the  
 7 contrary, it relies on precisely the sort of level-of-care analysis that Plaintiff argues was overly  
 8 restrictive when compared to GASC. The CD Guidelines themselves simply link to the LOC  
 9 Guidelines in the section that discusses level of care, underscoring the extent to which this letter  
 10 would qualify the recipient as a Subclass member.<sup>7</sup>

12 Considering all of the above, it cannot be said that individualized questions predominate  
 13 over the common ones in this case. Plaintiff has provided all that she must in order to equip the  
 14 parties and the court with a means for deciding whether each class member “has shown that his or  
 15 her claim was denied based on the wrong standard *and* that he or she might be entitled to benefits  
 16

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18 <sup>5</sup> As Plaintiff notes, the *Wit* court considered each of the mismatches alleged in her complaint. *See*  
*Wit* FFCL, 2019 WL 1033730, at \*22 n.12, \*28 n.13, \*29 n.14, \*35 n.16, \*31, \*34.

19 <sup>6</sup> The LOC Guidelines that Plaintiff does not challenge but which could nevertheless form the  
 20 basis of a denial are few. For example, one unchallenged aspect of the Guidelines is the  
 21 requirement that “the member’s family and other natural resources are engaged to participate in  
 22 the member’s treatment as clinically indicated.” *See* Ex. 2, Dkt. No. 100-2, at 3, 5, 10. Another  
 23 requires that treatment providers identify and integrate into the treatment and discharge plans all  
 24 “factors leading to admission.” *Id.* at 3, 5, 10. In the context of mental health residential  
 25 treatment, the Guidelines also require that the patient “is not in imminent or current risk of harm to  
 26 self, others, and/or property.” *Id.* at 7. To the extent that any of these criteria is the sole reason for  
 27 a denial letter, it would eliminate the relevant claimant from Subclass membership. Plaintiff has  
 28 convincingly demonstrated that the vast majority of denial letters, however, do not invoke these  
 grounds.

<sup>7</sup> Plaintiff also notes that less than 2% of Class members received a denial based on a CD  
 Guideline. The overwhelming majority of the class involves denials based on a LOC Guideline,  
 and the proposed subclass definition excludes anyone with a denial based on an unchallenged  
 LOC Guideline such that they would fail the *Wit* opinion’s second requirement.

under the proper standard.” *Wit*, 79 F.4th at 1084.

## 2. Superiority

To determine whether class proceedings are superior, a court considers “the whole range of practical problems that may render the class action format inappropriate for a particular suit.” *Eisen v. Carlisle and Jacquelin*, 417 U.S. 156, 164 (1974). “Although there is no explicit requirement concerning the class definition in FRCP 23, courts have held that the class must be adequately defined and clearly ascertainable before a class action may proceed.” *Schwartz v. Upper Deck Co.*, 183 F.R.D. 672, 679–80 (S.D.Cal.1999). “The superiority of a class action also depends on the existence of a realistic alternative to class litigation.” *Rowden v. Pacific Parking Sys.*, 282 F.R.D. 581, 584-85 (C.D. Cal. 2012); see also *Valentino*, 97 F.3d at 1234–35 (“A class action is the superior method for managing litigation if no realistic alternative exists.”)

UBH contends that class proceedings would be inferior to an individualized means of prosecuting the claims in this case. For support it cites *Rowden*, where superiority was not met because determining whether members were covered by the relevant statute turned on “an individual, fact-specific inquiry.” See 282 F.R.D. at 584-85. Here, by contrast, it is uncontested that the members are covered by ERISA. Moreover, the record reflects that some of the Subclass members have relatively small sums of money at stake, “sufficiently small as to economically deter separate actions to recover individual losses.” See *Abadilla v. Precigen Inc.*, No. 20-cv-6936-BLF, 2023 WL 7305053, at \*5 (N.D. Cal. Nov. 6, 2023). “The policy at the very core of the core of the class action mechanism is to overcome the problem that small recoveries do not provide the incentive for any individual to bring a solo action prosecuting his or her rights.” *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 617 (1997).

UBH also complains that the class may be defined “so broadly as to include a great number of members who for some reason could not have been harmed by the defendant’s

1 allegedly unlawful conduct.” *Castillo*, 980 F.3d at 730 (quoting *Torres v. Mercer Canyons Inc.*,  
2 835 F.3d 1126, 1138 (9th Cir. 2016)). That case, however, concerned a situation where the class  
3 definition included members who had not been exposed to the alleged harm or had not suffered  
4 monetary loss as a result; here, Plaintiff’s proposed Subclass is defined precisely to prevent such a  
5 situation.

6 UBH’s best argument is that Plaintiff’s subclass cannot be objectively ascertained. *See*  
7 *James v. Uber Techs. Inc.*, 338 F.R.D. 123, 130 (N.D. Cal. 2021) (highlighting the importance of  
8 “objective criteria” when ascertaining whether an individual is a class member). To be sure,  
9 “Rule 23 neither provides nor implies that demonstrating an administratively feasible way to  
10 identify class members is a prerequisite to class certification.” *Briseno v. ConAgra Foods, Inc.*,  
11 844 F.3d 1121, 1133 (9th Cir. 2017). Nevertheless, ensuring that the class can be ascertained  
12 through some fair and neutral criteria is a worthwhile endeavor. In this instance, it does appear  
13 that determining class membership will require textual analysis of the denial letters—analysis that  
14 could well hinge on the interests of whomever does the analyzing.

15  
16  
17 On balance, however, Plaintiff demonstrates that an objective examination of the letters  
18 will suffice to determine who’s in and who’s out of the Subclass. First, only those beneficiaries  
19 who actually paid for expenses that UBH denied will qualify—a yes or no question that can be  
20 readily and neutrally answered. Second, UBH itself coded the denial letters, so whether they cite  
21 a challenged Guideline is, in large part, predetermined. The only wiggle room is in the context of  
22 denial letters that mention unchallenged Guidelines, where determining whether a denial was  
23 based “solely” on the unchallenged Guidelines (and thus, beyond the scope of the class) could  
24 plausibly veer into subjective territory. As discussed *supra*, however, such instances will be rare:  
25 Plaintiff challenges almost every Guideline on which a denial could be based.

26  
27 Ultimately, and as noted in this court’s prior order, it is in the interest of judicial economy

to adjudicate the class members' challenge to the 2017 Guidelines, which is the main issue as to all of the putative class members, in a class action format." Class Cert. Order, 2021 WL 1318679, at \*9 (internal marks and citation omitted).

### C. The *Wit* standard

As should be clear at this point, Plaintiff's proposed modification satisfies not only the requirements of Rule 23 but also those set forth in the Ninth Circuit's *Wit* opinion. See 79 F.4th at 1084 (requiring that plaintiff seeking reprocessing must show that "her claim was denied based on the wrong standard" and that "she might be entitled to benefits under the proper standard."). As to the first prong, Plaintiff's proposed subclass definition includes only those members whose claims were denied at least in part due to a challenged Guideline. Plaintiffs' proposed definition likewise promises to include only members who might be entitled to benefits under the proper standard—that is, one which does not diverge from GASC in the ways Plaintiff alleges the 2017 Guidelines did.

UBH complains that Plaintiff's proposed subclass does not sufficiently protect against the inclusion of members who fail *Wit*'s two-prong showing, but its reasoning is unpersuasive. First, it argues that the Subclass definition only excludes those whose denial was based "solely" on an unchallenged Guideline, in contravention of *Wit*'s requirement that a reprocessing class be "limited to those claimants whose claims were denied based only on the challenged provisions of the Guidelines." 79 F.4th at 1086. What UBH overlooks, however, is that the *Wit* panel was concerned about "claimants who were denied coverage *solely* based on unchallenged provisions." *Wit*, 79 F.4th at 1085. As noted *supra*, nearly all the 2017 Guidelines on which a denial could be based *are* challenged here, so the fact that a Subclass member's denial letter cites those Guidelines will be a strong indicator that denial was not solely a result of unchallenged provisions.

As for denials based on both challenged and unchallenged Guidelines alike, the Ninth Circuit was hardly clear. On one hand, it held that a plaintiff becomes eligible for reprocessing if she makes “at least some showing that UBH employed an errant portion of the Guidelines that related to h[er] claim.” *Wit*, 79 F.4th at 1086. This language suggests that a Subclass member can seek reprocessing relief if her letter references both challenged and unchallenged Guidelines. Yet, in the same paragraph, the court held that the class’s inclusion of “members whose claims were denied in part based on the Guidelines” was “fatal.” *Id.* at 1085. This language suggests the opposite. Ultimately, Plaintiff has assured the court that the vast majority of reasons on which a denial could be based are challenged in this case—the risk of any claim denials based in part on unchallenged Guidelines is de minimis. Subclass members need only show that they “might be” entitled to benefits in order to seek reprocessing as a class. *Wit*, 79 F.4th at 1084; *see also Kazda*, 2023 WL 7305038 (“[T]he floor is a showing of possible prejudice.”). By demonstrating that their denials cited the Guidelines Plaintiff has challenged, such members demonstrate that they might be entitled to benefits if UBH uses Guidelines consistent with GASC.

## V. CONCLUSION

Consistent with the foregoing, Defendant’s motion to decertify is denied and Plaintiff’s motion to modify is granted. The class definition is amended and the proposed Subclass is certified as follows:

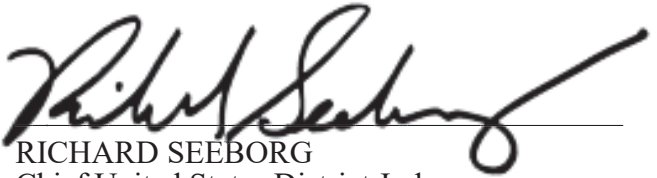
Any member of the Class who incurred expenses for residential treatment for which benefits were not paid, except that the Reprocessing Subclass shall not include Class members whose written notification of denial, as reflected in UBH’s records, (a) identifies a reason for denying the request for coverage other than the Class member’s failure to satisfy UBH’s 2017 LOCGs or a Coverage Determination Guideline that incorporates the 2017 LOCGs, and/or (b) specifies that the member’s failure to satisfy the applicable Guideline was based solely on a portion of the applicable Guideline that was unchallenged in this action.

Plaintiff is appointed as representative for the Subclass. Defendant having no objection,

Plaintiff's counsel from Zuckerman Spaeder LLP and Psych-Appeal, Inc. are appointed subclass counsel.<sup>8</sup>

**IT IS SO ORDERED.**

Dated: April 14, 2025

  
RICHARD SEEBORG  
Chief United States District Judge

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<sup>8</sup> In connection with the motions to decertify or modify the class, both parties have moved to seal a number of exhibits filed in support of their respective briefing, as well as portions of the briefing which reference the exhibits. *See* Dkt Nos. 99, 110, 126, 130, 135, 138, 141. Collectively, these motions amount to a narrowly-tailored request that certain individuals' potentially sensitive health records be kept from the judicial record. Because these requests do not unduly burden the public's interest in access to court materials, they are hereby granted.