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United States District Court  
Northern District of California

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

LAURA B,  
Plaintiff,  
v.  
UNITED HEALTH GROUP COMPANY, et  
al.,  
Motion Pictures.

Case No. [16-cv-01639-JSC](#)

**ORDER DENYING MOTION FOR  
SUMMARY JUDGMENT**

Re: Dkt. Nos. 43, 44, 45

Plaintiff Laura B sues Defendant Motion Picture Industry Health Plan (“Motion Picture” or “MPIHP”) for the denial of coverage for Plaintiff’s mental health inpatient care. (Dkt. No. 27.) Motion Picture moves for summary judgment arguing Plaintiff failed to exhaust her administrative remedies, the denial decision is reviewable only for an abuse of discretion, and the Court’s review is limited to the administrative record. (Dkt. No. 44.) Because the plan documents do not require a second level appeal to Motion Picture to exhaust administrative remedies and Motion Picture has not met its burden to show that abuse of discretion review applies, Motion Picture’s motion for summary judgment is DENIED.

**BACKGROUND**

**I. Denial of Plaintiff’s Benefits Claim.**

Plaintiff participated in Motion Picture’s employee welfare benefit plan (the “Plan”) sponsored by Plaintiff’s employer and administered by Optum Health Behavioral Solutions, Inc. (“Optum”). (Second Amended Complaint “SAC” ¶ 5, Dkt. No. 43-2 ¶ 4.) At all relevant times, the Plan was a self-funded. (SAC at 2 ¶ 6.) Plaintiff was diagnosed with and suffers from major depressive order, generalized anxiety disorder, and post-partum depression. (SAC ¶ 8.) On

1 approximately September 30, 2013, Plaintiff stopped working due to her disability. (SAC ¶ 10.)  
2 Between October 28, 2014 through November 3, 2014 and January 7, 2015 through January 20,  
3 2015, Plaintiff was hospitalized and received inpatient mental health treatment at Resnick  
4 Neuropsychiatric Hospital at the University of California, Los Angeles. (Dkt No. 43-11 at 100-  
5 105.) Plaintiff filed behavior health claims for this treatment, which was approved by Optum. (Id.  
6 at 90-99.)

7 Plaintiff sought further inpatient services at Balance Treatment Center on January 16,  
8 2015. (Dkt. No. 43-10 at 167-168.) Optum denied coverage for treatment at Balance, instead  
9 authorizing Mental Health Acute Inpatient Unit as an alternate service. (Id.) Plaintiff submitted an  
10 urgent appeal to Optum on January 21, 2015. (Id. at 161.) By letter dated January 22, 2015,  
11 Optum wrote to Plaintiff advising that it had completed the appeal review for residential treatment  
12 at Balance. (Id. at 161-65.) Optum denied benefit coverage for treatment at Balance and instead  
13 authorized Mental Health Partial Hospitalization as an alternate service. (Id.)

14 A document entitled “Important Information About Your Right to Request a Second-Level  
15 Review of a Non-Coverage Determination” was enclosed with the January 22 Optum denial letter  
16 and includes the following two paragraphs:

17 Under the terms of your benefit with Motion Picture Industry Pension & Health  
18 Plans, you have a right to request a Second-Level appeal review of any decision not  
19 to provide you a benefit or pay for an item or service (in whole or in part).  
20 The decision of the Benefits/Appeals Committee shall be final and binding upon all  
parties, including the Participants and any person claiming under the Participant,  
subject to the right to bring a civil action under 502(a) of ERISA.

21 (Dkt. No. 43-10 at 164-165.) On February 13, 2015, Plaintiff’s provider at the Balance Treatment  
22 Center, medical director Dr. Ronald D. Sager, submitted a letter to Optum stating that Plaintiff  
23 “continues to meet medical necessity for residential care” due to her depression and anxiety. (Dkt.  
24 No. 47-1 at 14.) According to Plaintiff this letter was not contained in the initial disclosures or  
25 administrative record produced by Motion Picture. (Dkt. No. 47-1 at 2 ¶ 4.)

26 **II. The Plan Documents**

27 **A. The Agreement and Declaration of Trust (“Trust Agreement”)**

28 The Trust Agreement under which the Plan operates provides discretionary authority to the

1 Plan’s Directors. Art. IV, Section 1 grants the Directors the power to construe the Trust  
2 Agreement. (Dkt. No. 43-4 at 16.) The Directors have full authority to determine the benefits the  
3 Plan will provide and final and binding authority to determine claims and appeals. (Dkt. No. 43-5  
4 at 7, 10.) The Trust Agreement also grants the Directors the authority to interpret the plan of  
5 benefits. (Id. at 11.)

6 **B. The 2013 Summary Plan Description (“SPD”)**

7 The SPD recites the Motion Picture’s Board of Directors “full discretion and authority to  
8 interpret the Plan and to decide any factual questions related to eligibility for and the extent of  
9 benefits provided by the Plan.” (Dkt. No. 43-9 at 14.) The SPD includes a section titled:  
10 “CLAIMS APPEALS PROCEDURES.” Under the subheading “Filing An Appeal with MPIHP,”  
11 the SPD states: “if you feel that your Claim has not be processed correctly by MPIHP, you have  
12 180 days following the receipt of your Explanation of Benefits or other initial adverse  
13 determination to make a formal request for review.” (Dkt. No. 43-10 at 70.) Appeals must be  
14 addressed to the “Benefits/Appeals Committee” of MPIHP. (Id.) Under the same subheading, the  
15 SPD states that the Committee’s decision “shall be final and binding upon all parties, including the  
16 Participants and any person claiming under the Participant, subject to the right to bring a civil  
17 action under Section 502(a) of ERISA.” (Id. at 70.) It goes on to warn that “[t]he failure to file  
18 such an appeal within 180 days from your receipt of the initial Adverse Benefit Determination  
19 shall constitute a waiver of the right to review the decision.” (Id.)

20 Under the same “CLAIMS APPEALS PROCEDURES” section, is a separate subheading  
21 entitled “Filing Appeals with MPIHP Contract Providers.” There the SPD states that appeals for  
22 health care services made through contract providers are “generally handled by the entities  
23 themselves, rather than by [Motion Picture].” (Id.)

24 **DISCUSSION**

25 Motion Picture makes three summary judgment arguments: (1) this Court must review the  
26 benefits determination for abuse of discretion, (2) Plaintiff failed to exhaust her administrative  
27 remedies as the Plan requires; and (3) the Court’s review of the benefits decision is limited to the  
28 administrative record of Plaintiff’s claim. (Dkt. No. 44 at 5.)

1     **I.     Standard of Review**

2             “The default standard for evaluating a claim for benefits under ERISA is de novo.” Wiley  
3 v. Cendant Corp. Short Term Disability Plan, 631 F.Supp.2d 1221, 1224 (N.D. Cal. 2009) (citing  
4 Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)). However, when an ERISA  
5 plan “grants discretionary authority to the plan administrator to determine plan eligibility, the  
6 court will ordinarily review a committee’s decision to deny benefits for an abuse of discretion.”  
7 Bergt v. Retirement Plan for Pilots Employed by MarkAir, Inc., 293 F.3d 1139, 1142 (9th Cir.  
8 2002) (citing Firestone, 489 U.S. at 115). The plan documents must “grant this discretionary  
9 authority unambiguously; if the plan fails to do this, the district court must review a committee’s  
10 decision de novo.” Id. (citing Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (1999)).

11             **A.     California Insurance Code Section 10110.6 Does not Apply**

12             Plaintiff first argues that the Court need not even look at the Plan language because  
13 California Insurance Code Section 10110.6 voids insurance provisions that reserve discretionary  
14 authority to the insurer or its agent to determine eligibility for benefits or interpret the terms of the  
15 policy. Cal. Ins. Code § 10110.6. This argument fails, however, because ERISA preempts state  
16 laws that regulate self-funded plans and it is undisputed that “at all relevant times, the Plan was a  
17 self-funded plan.” (SAC at 2 ¶ 6.)

18             “ERISA contains one of the broadest preemption clauses ever enacted by Congress.”  
19 Evans v. Safeco Life Ins. Co., 916 F.2d 1437, 1439 (9th Cir. 1990). Except as provided in 29  
20 U.S.C Section 1144(b), ERISA supersedes “any and all State laws insofar as they may now or  
21 hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). ERISA’s “savings clause”  
22 contains an exception: “[N]othing in this subchapter shall be construed to exempt or relieve any  
23 person from any law of any State which regulates insurance.” Id. § 1144(b)(2)(A). However,  
24 “[i]n FMC v. Holliday, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990), and Metropolitan  
25 Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), the Supreme  
26 Court recognized that ERISA—specifically the interaction of the savings and deemer clauses with  
27 the general preemption clause—treats insured plans and self-funded plans differently for  
28 preemption purposes.” PM Group Life Ins. Co. v. Western Growers Assur. Trust, 953 F.2d 543,

1 545 (9th Cir. 1992). “ERISA’s ‘deemer clause’ provides that self-funded ERISA plans may not be  
2 deemed to be insurers or insurance companies for purposes of the savings clause.” Vrijesh S.  
3 Tantuwaya MD, Inc. v. Anthem Blue Cross Life and Health Insurance Company, 169 F.Supp.3d  
4 1058, 1071 (S.D. Cal. Mar. 11, 2016) (citing FMC, 498 U.S. at 61); see also PM Group, 953 F.2d  
5 at 545-46 (holding that because that the defendants were self-funded plans, ERISA preempted the  
6 application of California law to the plans).

7 Because the Plan was self-funded, it falls under ERISA’s deemer clause and may not be  
8 considered an insurance company for purposes of the savings clause. See FMC, 498 U.S. at 61.  
9 As such, ERISA preempts the application of California Insurance Code Section 10110.6 to the  
10 Plan. See Martin v. Aetna Insurance Company, 223 F.Supp.3d 973, 981-82 (C.D. Cal. 2016).  
11 Plaintiff’s reliance on Standard Ins. Co. v. Morrison, 584 F.3d 837 (9th Cir. 2009) is misplaced as  
12 the case does not address the application of the ERISA savings clause to self-funded plans.

13 Although not raised by Plaintiff, the Court notes that the Ninth Circuit recently held in  
14 Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, 856 F.3d 686 (9th Cir. 2017)  
15 that Insurance Code section 10110.6 was saved from ERISA preemption by the savings clause.  
16 Orzechowski, however, did not address FMC or the deemer clause which is unsurprising given  
17 that the plan appeared to have been funded by an insurance policy rather than being self-funded.  
18 See id. at 688 (noting that Aetna Life Insurance Company decided to terminate the plaintiff’s long-  
19 term disability benefits).

20 In any event, after this Court heard oral argument the Ninth Circuit decided the issue. In  
21 Williby v. Aetna Life Insurance Co., the court discussed whether state law applies to a self-funded  
22 employee benefit plan. 2017 WL 3482390, \*1 (9th Cir. Aug. 15, 2017). The Ninth Circuit held it  
23 does not:

24 If the state law is applied to a traditional insurance policy, then the state law falls  
25 outside the deemer clause and thus within the saving clause—even if the insurance  
26 policy backstops an ERISA plan. On the other hand, if the state law is applied to  
27 an ERISA plan itself, which is how such laws operate on self-funded plans, the law  
28 falls within the deemer clause and thus is preempted, even if it is a bona fide  
insurance regulation that only incidentally affects ERISA concerns. See FMC  
Corp., 498 U.S. at 64, 111 S.Ct. 403. The result is a simple, bright-line rule: “if a  
plan is insured, a State may regulate it indirectly through regulation of its insurer

1 and its insurer's insurance contracts; if the plan is uninsured, the State may not  
2 regulate it.” Id. The [FMC] Court thus concluded: “We read the deemer clause to  
3 exempt self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within  
4 the meaning of the saving clause.” Id. at 61, 111 S.Ct. 403; see Scharff v. Raytheon  
5 Co. Short Term Disability Plan, 581 F.3d 899, 907 (9th Cir. 2009)(“[U]nder  
6 ERISA’s ‘deemer clause,’ state insurance regulation of self-funded plans is  
7 preempted by ERISA.”). Thus, for a self-funded disability plan like Boeing’s, the  
8 saving clause does not apply, and state insurance regulations operating on such a  
9 self-funded plan are preempted.

10 (Id. at \*5-6.) ERISA therefore preempts the application of California Insurance Code section  
11 10110.6 to Motion Picture’s self-funded plan.

12 **B. Motion Picture did not Show That Optum has Discretion to Make Benefits  
13 Determinations**

14 Optum—not Motion Picture—made the decision to deny Plaintiff benefits. Motion Picture  
15 has not met its burden of showing that abuse of discretion review applies to Optum’s decision.  
16 See Prichard v. Metropolitan Life Ins. Co., 783 F.3d 1166, 1169 (9th Cir. 2015). Its motion for  
17 summary judgment argued only that Motion Picture has discretionary authority to determine  
18 eligibility for benefits and did not address whether Motion Picture had properly delegated that  
19 authority to Optum. (Dkt. No. 44.) Accordingly, Motion Picture has not met its burden of  
20 showing that abuse of discretion review applies.

21 Its attempt to meet its burden in connection with its reply is too little too late. That Optum  
22 and not Motion Picture made the eligibility decision was not something that Motion Picture  
23 learned from Plaintiff’s opposition; Motion Picture had full knowledge of that fact before it filed  
24 its motion for summary judgment. Indeed, it moved for summary judgment on the grounds that  
25 Plaintiff failed to exhaust her administrative remedies based on the undisputed fact that Motion  
26 Picture was never given the opportunity to decide eligibility for benefits. Its attempt to offer new  
27 evidence and argument in its reply, indeed a whole new delegation theory, is improper and will not  
28 be considered by the Court on summary judgment. See Provenz v. Miller, 102 F.3d 1478, 1483  
(9th Cir. 1996).

While the Court could give Plaintiff the opportunity to file a sur-reply to address  
Defendant’s new evidence and argument, given that Plaintiff did not cross-move for summary  
judgment on the appropriate standard of review, and that the parties’ Rule 52 submissions are due

1 in November, the Court concludes that the best approach is to address this question in connection  
2 with the Rule 52 briefing. Thus, the question of whether Optum had discretion to decide  
3 eligibility for benefits such that abuse of discretion rather than de novo review applies will be  
4 decided at the same time as the Court’s merits decision.

5 **II. Administrative Exhaustion**

6 Having realized that Motion Picture did not make the decision to deny Plaintiff benefits,  
7 Motion Picture also moved for summary judgment on the grounds that Plaintiff failed to exhaust  
8 her mandatory administrative remedies.<sup>1</sup>

9 “As a general rule, an ERISA claimant must exhaust available administrative remedies  
10 before bringing a claim in federal court.” *Barboza v. California Association of Professional*  
11 *Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011). “Under ERISA, an employee benefit plan’s  
12 internal review procedures must be included in the plan’s written documents, which include the  
13 plan instrument, see 29 U.S.C. § 1102(a)(1), and a summary of the plan instrument, called the  
14 ‘summary plan description.’” *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620,  
15 627 (9th Cir. 2008) (citing 29 U.S.C. § 1022). “The summary plan description must be ‘written in  
16 a manner calculated to be understood by the average plan participant,’ and must be ‘sufficiently  
17 accurate and comprehensive to reasonably apprise such participants and beneficiaries of their  
18 rights and obligations under the plan.’” *Id.* (citing 29 U.S.C § 1022(a)).

19 The summary plan description must contain “the remedies available under the plan for the  
20 redress of claims which are denied in whole or in part.” *Id.* (citing 29 U.S.C. § 1022(b)). “If there  
21 is ambiguous language in a plan, ambiguities are construed in favor of the insured.” *Wiley v.*  
22 *Cendant Corp. Short Term Disability Plan*, 631 F.Supp.2d 1221, 1224 (citing *Kearney*, 175 F.3d  
23 at 1090).

24  
25 \_\_\_\_\_  
26 <sup>1</sup> Plaintiff argues that exhaustion of administrative remedies must be raised in a 12(b) motion to  
27 dismiss rather than summary judgment. However, both of the cases upon which Plaintiff relies  
28 were later overruled by *Albino v. Baca*, 747 F.3d 1162 (9th Cir. 2014). *Albino* applies to ERISA  
cases. See *Norris v. Mozzola*, 2016 WL 1588345, at \*6 (N.D. Cal. Apr. 20, 2016). As the *Albino*  
court explained, the procedure for resolving exhaustion of remedies questions is a summary  
judgment motion, “followed, if necessary, by a decision by the court on disputed questions of  
material fact relevant to exhaustion.” 747 F.3d at 1171.

1           Because lack of ERISA exhaustion is an affirmative defense, see *Norris v. Mozzola*, 2016  
2 WL 1588345, at \*6 (N.D. Cal. Apr. 20, 2016) (citing cases), “[d]efendants must produce evidence  
3 proving failure to exhaust in order to carry their burden.” *Albino v. Baca*, 747 F.3d 1162, 1166  
4 (9th Cir. 2014). “If undisputed evidence viewed in the light most favorable to the [plaintiff]  
5 shows a failure to exhaust, a defendant is entitled to summary judgment under Rule 56.” *Id.*

6           Defendant Motion Picture has not met its burden because nowhere in the Plan documents  
7 does it state that a claimant is required to make a second level appeal to Motion Picture’s  
8 Benefits/Appeals committee before bringing an ERISA suit. The SPD states “if you feel that your  
9 Claim has not be processed correctly by MPIHP, you have 180 days following the receipt of your  
10 Explanation of Benefits or other initial adverse determination to make a formal request for  
11 review.” This language did not require Plaintiff to file an appeal with the Motion Picture  
12 Benefits/Appeals Committee as her claim was not processed by MPIHP in the first instance—it  
13 was processed by Optum. And, indeed, in a separate subsection the SPD states that appeals may  
14 be handled by contract providers, such as Optum. An average plan participant could conclude  
15 from the SPD’s plain language that when a benefit is offered through a contract provider it is that  
16 contract provider, rather than Motion Picture, that handles the entire appeal process. Indeed,  
17 Plaintiff addressed her appeal documents to Optum. Thus, to an average participant whose claim  
18 has been denied by a Motion Picture contract provider this language does not require an appeal to  
19 the Motion Picture Benefits/Appeals Committee.

20           The SPD’s proclamation that “the decision of Motion Picture’s appeals committee shall be  
21 final and binding upon all parties, including the Participants and any person claiming under the  
22 Participant, subject to the right to bring a civil action under Section 502(a) of ERISA” does not  
23 obligate a claimant in Plaintiff’s position to file an appeal with the Motion Picture  
24 Benefits/Appeals Committee. First, as explained above, it does not address the issue that Plaintiff  
25 never had her claim denied by Motion Picture in the first instance and thus that this subsection  
26 does not apply at all. Second, the language does not inform a claimant that she is obligated to file  
27 a secondary appeal directly to the Motion Picture Benefits/Appeals Committee prior to filing an  
28 ERISA action. The Seventh Circuit’s decision in *Gallegos v. Mount Sinai Medical Center*, 210



1 F.3d 803 (7th Cir. 2000) is right on point. There the court held that the claimant was not required  
2 to file an appeal where “the only penalty mentioned for failure to submit to administrative review  
3 is that the claims decision will become ‘final.’ There is no indication that this ‘finality’ may have  
4 consequences for the bringing of a suit in federal court, an option which the claimant is also  
5 informed she may pursue.” Id. at 810.

6 The same is true here. There is nothing in the SPD that suggests that the “finality” of the  
7 decision means that a claimant cannot bring suit in court. To the contrary, the language stating  
8 that it is final and binding “subject to the right to bring a civil action” suggests that the decision is  
9 reviewable by a court, not that it is not reviewable. Further, the statement two paragraphs later  
10 that failure to file an appeal with the Motion Picture Benefits/Appeals Committee within 180 days  
11 “shall constitute waiver of the right to review the decision” also does not advise the average  
12 participant that she will lose her right to go to court if she does not file an appeal. Review by  
13 whom? The natural reading is that review by the Committee is waived, not review under ERISA  
14 by a court. In Vaught, in contrast to the language here, the claimant was clearly advised that there  
15 were two levels of review and that the claimant had a right to bring a claim in court only after  
16 receiving adverse benefit determinations at both levels of review. 546 F.3d at 623.

17 The letter denying Plaintiff’s first level appeal also did not obligate Plaintiff to file an  
18 appeal with the Motion Picture Benefits/Appeals Committee. The letter merely states Plaintiff has  
19 “a right to” a second appeal. While the Ninth Circuit has not opined on what language conveys  
20 mandatory appeal procedures, at least two other circuits have held that the plain meaning of  
21 phrases such as “you may have your claim reviewed,” “you may appeal,” and “if you wish to have  
22 the decision reviewed” indicates the ability to participate in a voluntary, rather than mandatory,  
23 review procedure. See Gallegos v. Mount Sinai Medical Center, 210 F.3d 803, 810 (7th Cir.  
24 2000); Watts v. BellSouth Telecommunications, Inc., 316 F.3d 1203, 1208 (11th Cir. 2003); see  
25 also Lecates v. Blue Cross Idaho, 2017 WL 4974950, \*7 (D. Idaho Sept. 16, 2016) (concluding  
26 the plain meaning of the words “may”, “wish”, or “should” indicate that a plan participant has the  
27 opportunity to participate in a voluntary, rather than mandatory, review procedure). Telling a  
28 participant she has “a right to” an appeal is not the same as telling a claimant she must appeal or

1 she loses her right to challenge the decision in court. As the Eleventh Circuit explained in Watts:

2 The summary plan description tells participants that they “may use” the  
3 administrative appeal procedure if their claim is denied and they “wish to appeal”  
4 and, on the very next page, states that claimants “may” file a suit in federal court if  
5 their claim is denied. In neither place, or anywhere else in the document, does it say  
6 that using the administrative appeal procedure is **necessary** before a lawsuit may be  
7 filed. By describing without limitation either route as one the participant “may” use  
8 to obtain relief from the denial of her claim, the clear implication is that neither is a  
9 prerequisite for the other. To attorneys and judges familiar with the law in general  
10 and with ERISA law in particular, it may seem obvious that administrative  
11 remedies must come before a lawsuit, but to the average plan participant, who by  
12 virtue of being an ERISA claimant will sometimes be sick or disabled, there is  
13 nothing obvious about it. Instead, it is more likely that a layperson told that she  
14 “may” exhaust her administrative remedies and that she “may” file a lawsuit would  
15 conclude, as Watts did, that it was an either/or proposition-her option.

16 *Id.* at 1208 (emphasis added). The same reasoning applies here.

17 Defendant’s reliance on *Noren v. Jefferson Pilot Financial Ins. Co.* 378 Fed.Appx 696  
18 (9th Cir. 2010) is misplaced. There the court concluded that the plan required two levels of  
19 internal administrative review and “the appeal procedure was fully contained in the plan  
20 information.” *Id.* at 697-98. *Noren* thus sheds no light on whether this Plan, SPD, and denial  
21 letter adequately advised an average claimant that she was required to file two appeals or be barred  
22 from filing suit. They did not. Defendant’s emphasis on Plaintiff’s failure to come forward with  
23 evidence that she “failed in her duty” to file a second appeal because she misunderstood the appeal  
24 process is also unavailing. She does not have to produce such evidence because the Plan  
25 documents failed to create such a duty in the first place.

26 As Defendant has not established that the Plan, SPD or denial letter obligated Plaintiff to  
27 file a second level review with the Motion Picture Benefits/Appeals Committee before filing an  
28 ERISA lawsuit, Defendant’s motion for summary judgment on the grounds that Plaintiff failed to  
exhaust her administrative remedies is denied.

### 29 **III. Scope of Review**

30 Defendant argues that since the standard of review is abuse of discretion, the Court may  
31 not consider any evidence outside the administrative record. As discussed above, the Court has  
32 not yet determined the standard of review. Moreover, evidence outside the administrative record

1 may be relevant to the standard of review inquiry, and there may be a dispute as to what is in the  
2 administrative record. The Court thus denies Defendant’s motion to limit the scope of review.

3 **IV. Plaintiff’s Motion for Administrative Relief**

4 Plaintiff moves for administrative relief to postpone any consideration of whether Plaintiff  
5 exhausted her administrative remedies and the scope of the administrative record. (Dkt. No. 45.)  
6 The Court addressed the issues of exhaustion and scope above therefore Plaintiff’s motion is  
7 denied.

8 **VI. Motion to File Under Seal**

9 A party must demonstrate “compelling reasons” to seal judicial records attached to a  
10 dispositive motion. *Kamakana v. City & Cnty. of Honolulu*, 447 F.3d 1172, 1179 (9th Cir.  
11 2006). Parties moving to seal documents must comply with the procedures set forth in Civil Local  
12 Rule 79-5. The rule permits sealing only where the parties have “establishe[d] that the document  
13 or portions thereof is privileged or protectable as a trade secret or otherwise entitled to protection  
14 under the law.” Civ. L.R. 79-5(b).

15 Motion Picture argues Exhibit A to the Bonanno declaration, the administrative record of  
16 the benefit denial, merits sealing because it contains Plaintiff’s identifiable information including  
17 claims for medical benefits, home address, and social security number. (Dkt. No. 43-1 at 1.)  
18 Motion Picture’s attempt to seal Exhibit A in its entirety is improper. Exhibit A contains several  
19 documents and hundreds of pages, including Motion Picture’s Trust Agreement and SPD, that do  
20 not identify Plaintiff’s personal information. Accordingly, Motion Picture is ordered to resubmit  
21 its motion to file under seal with the appropriate redactions for Plaintiff’s identifying information.

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**CONCLUSION**

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For the reasons outlined above, the Court DENIES Motion Picture’s motion for summary judgment, motion to file under seal, and Plaintiff’s motion for administrative relief.

This Order disposes of Docket Nos. 43, 44, and 45.

**IT IS SO ORDERED.**

Dated: August 25, 2017

  
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JACQUELINE SCOTT CORLEY  
United States Magistrate Judge