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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of THE TECHNOLOGY ACCESS FOUNDATION HEALTH BENEFIT PLAN, and on behalf of similarly situated individuals,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, *et al.*,

Defendants.

No. C11-1119RSL

ORDER GRANTING  
PLAINTIFFS' MOTIONS FOR  
SUMMARY JUDGMENT

This matter comes before the Court on Plaintiffs' "Motion for Summary Judgment re: Exhaustion of Administrative Remedies" (Dkt. # 43) and "Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and Injunctive Relief under ERISA" (Dkt. # 44). Plaintiffs ask the Court to find as a matter of law that they exhausted their administrative remedies or that those remedies would be futile and to enter a permanent injunction requiring Defendants to comply with the requirements of Washington's Mental Health Parity Act, RCW 48.46.291, which the Court previously found to apply. The Court finds that Plaintiffs have exhausted their administrative remedies. It further finds that Plaintiffs are entitled to a permanent injunction requiring Defendants to adhere to the plain requirements of Washington's Mental Health Parity Act. Accordingly, the Court GRANTS both motions.

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## I. BACKGROUND

This case concerns a dispute over healthcare benefits. Plaintiff Z.D. is the twelve-year-old daughter and dependant of Plaintiffs J.D. (her mother) and T.D. (her father). See Dkt. # 45 at ¶ 2. She is a beneficiary of “The Technology Access Foundation Health Benefit Plan” (the “Plan”), an ERISA “employee welfare benefit plan,” 29 U.S.C. § 1002(1), underwritten and administered by Defendant Group Health Options, Inc.—a wholly owned subsidiary of Defendant Group Health Cooperative. Amended Complaint (Dkt. # 3) at ¶¶ 1–5.

In 2006, Defendant Group Health diagnosed Z.D. with two DSM-IV-TR mental health conditions: a “moderate-severe receptive language disorder” and “other specific developmental learning disabilities.” Dkt. # 45 at ¶ 4; see also Dkt. # 49-1 (Exhibit B).<sup>1</sup> At the time of her diagnoses, Z.D. was already a beneficiary of the Plan and began receiving covered non-“restorative”<sup>2</sup> speech therapy treatment for her conditions. Circumstances changed, however, shortly before Z.D.’s seventh birthday. Plaintiff was told that, per the Plan, non-restorative speech therapy treatments were not covered for individuals over the age of six and thus her treatments would no longer be covered once she turned seven. Dkt. # 45 at ¶ 5. As a result, Z.D. stopped going to outpatient therapy, though she did receive some limited treatment services through her public elementary school. Id. at ¶ 6; Dkt. # 49-1 at 21.

Unfortunately, this limited therapy did not seem to be enough. Six months after Z.D.’s seventh birthday, her mother complained to Z.D.’s doctor that Z.D. was

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<sup>1</sup> The Court notes that this exhibit is sealed and, because it prefers that the present Order be accessible by the public, has not disclosed any information not otherwise available from the parties’ public filings. Nevertheless, throughout this Order the Court will cite to sealed documents that it considered but is not publicly disclosing in order to build a more thorough record in the event of an appeal.

<sup>2</sup> The Plan distinguishes between “restorative” treatment, which is intended to restore function and is covered regardless of age, and “non-restorative” treatment, which is intended to improve function and is not covered for individuals older than seven. E.g., Dkt. # 56-1 at 28.

1 continuing to experience problems at school. In October 2007, Z.D. was evaluated  
2 extensively at the University of Washington’s LEARN Clinic, which confirmed Group  
3 Health’s earlier diagnosis. Dkt. # 45 at ¶ 6; see Dkt. # 49-1 at 19–37. Group Health  
4 covered this evaluation. Dkt. # 57 at ¶ 4; Dkt. # 57-1 at 2.

5 On November 28, 2007, J.D. phoned Group Health to ask if Group Health would  
6 cover speech therapy for Z.D. Dkt. # 50-1 at 83; Opp. (Dkt. # 54) at 8. According to  
7 Group Health’s records, it told her that Z.D.’s therapy would not be covered because she  
8 was over the age of six. Dkt. # 50-1 at 83.

9 In 2008, Z.D.’s parents began paying for her to receive treatment at Bellevue  
10 Mosaic in 2008. Dkt. # 45 at ¶ 7. In late 2008, Bellevue Mosaic recommended that  
11 Z.D. seek a higher level of treatment than it could provide. Id. at ¶ 8. Her parents took  
12 her to Northwest Language and Learning Center in September 2008. Id. Shortly after,  
13 J.D. emailed Group Health about coverage. Dkt. # 45-1 at 6–7. After she provided  
14 some extra information requested by Group Health, id. at 8, she received a formal denial  
15 of coverage on December 18, 2008. Group Health explained that “neurodevelopmental  
16 speech therapy is not covered beyond the age of 6” and that Northwest Learning and  
17 Language was not a provider within the Group Health system.”<sup>3</sup> Id. at 11. Z.D.’s  
18 parents sent her to the center anyway, paying for her treatment out of pocket beginning  
19 in January 2009. Dkt. # 45 at ¶ 11.

20 On September 15, 2010, Z.D. received an evaluation from Dr. Deborah Hill. Id.  
21 at ¶ 12. On October 15, J.D. sent Group Health another letter informing them of its  
22 prior age-based denials of her requests for treatment for Z.D. and asking it to reconsider  
23 its position. Dkt. # 45-1 at 18. She explained that she intended to enroll Z.D. at the  
24 Northwest Language and Learning Center and added: “Please consider this letter to be  
25 an appeal of Group Health’s denial of my requests for speech therapy and

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26 <sup>3</sup> This rationale is somewhat curious given that Group Health covered Z.D.’s  
September and October sessions at Northwest. Dkt. # 57-1 at 4.

1 neurodevelopmental evaluation for my daughter.” Id. She also included a claim for  
2 reimbursement for the September 15 evaluation. Id. at 19–21.

3 Group Health responded in a letter dated November 1, 2010. Id. at 23. It stated  
4 that it did not have any record of having denied coverage for the September evaluation  
5 and would forward her claim to the claims department. Id.

6 J.D. responded via a certified letter dated December 9, 2010. Id. at 25. She  
7 wrote that she had not heard anything further from Group Health in regard to either her  
8 general request for coverage or her specific claim for the September evaluation. Id. She  
9 explained that because she had not received any explanation of benefits in regard to her  
10 request for coverage, she considered Group Health’s inaction to be a denial and wished  
11 to appeal that denial. Id. Group Health states that it never received that letter. Opp.  
12 (Dkt. # 54) at 11. It did eventually “cover” the September 15 claim, though. Compare  
13 Dkt. # 45 at ¶ 17 (stating that Group Health paid the claim), with Dkt. # 57 at ¶ 6  
14 (stating that Group Health denied coverage because Plaintiffs had used the maximum  
15 number of mental health evaluations to which they were entitled, but that Plaintiffs still  
16 received the benefit of Group Health’s lower rate).

17 In any case, Plaintiffs continued to send Z.D. to Northwest, paying for her  
18 therapy themselves. Dkt. # 45 at ¶ 17. On July 6, 2011, they filed the instant suit  
19 against Defendants, alleging that Washington’s Mental Health Parity Act, RCW  
20 48.46.291, requires Defendants to cover Z.D.’s mental health therapy sessions.  
21 Complaint (Dkt. # 1). They seek to recover the “benefits due them due to the improper  
22 exclusion and/or limitations of behavioral and neurodevelopmental therapy.” Amended  
23 Complaint (Dkt. # 3) at ¶¶ 36–38 (relying on 29 U.S.C. § 1132(a)(1)(B)). And they seek  
24 the recovery of all losses to the Plan for Defendants’ alleged failure “to act in  
25 accordance with the documents and instruments governing the Plan.” Id. at ¶¶ 28–35  
26 (relying on 29 U.S.C. § 1132(a)(2) (“breach of fiduciary duty”). Finally, they ask the

1 Court to enjoin Defendants from continuing to process and pay claims in a manner  
2 inconsistent with RCW 48.46.291. Id. at ¶¶ 39–41 (relying on 29 U.S.C. § 1132(a)(3)).

3 After filing suit, Plaintiffs filed a claim for each of Z.D.’s 2011 sessions at  
4 Northwest. Dkt. # 45 at ¶ 17. Group Health tendered a check in payment of these  
5 claims on November 17, 2011. Id. In a subsequent deposition, however, Group Health  
6 stated that it had erroneously tendered that payment. Dkt. # 48-1 at 60–61 (“[I]t should  
7 not have been paid.”).

## 8 **II. DISCUSSION**

9 In the present motions, Plaintiffs argue first that they are entitled to a legal  
10 finding that they exhausted their administrative remedies or that those remedies would  
11 have been futile. Dkt. # 43. Moreover, they ask the Court to enter a permanent  
12 injunction against Defendants, enjoining “Group Health from denying coverage for  
13 medically necessary neurodevelopmental therapy to treat insureds with DSM-IV-TR  
14 mental health conditions simply because the insured is over six years old.” Dkt. # 44.

15 Notably, the Court may grant Plaintiffs’ motions only if it is satisfied that there is  
16 no genuine issue of material fact and that judgment is appropriate as a matter of law.  
17 Fed. R. Civ. P. 56(c). As the moving party, Plaintiffs bear the initial burden of  
18 informing the Court of the basis for summary judgment. Celotex Corp. v. Catrett, 477  
19 U.S. 317, 323 (1986). They must prove each and every element of their claims or  
20 defenses such that no reasonable jury could find otherwise. Anderson v. Liberty Lobby,  
21 Inc., 477 U.S. 242, 248 (1986). In doing so, they are entitled to rely on nothing more  
22 than the pleading themselves. Celotex, 477 U.S. at 322–24. Only once they make their  
23 initial showing does the burden shift to the Defendants to show by affidavits,  
24 depositions, answers to interrogatories, admissions, or other evidence that summary  
25 judgment is not warranted because a genuine issue of material fact exists. Id. at 324.

26 To be material, the fact must be one that bears on the outcome of the case. A  
genuine issue exists only if the evidence is such that a reasonable trier of fact could

1 resolve the dispute in favor of the nonmoving party. Anderson, 477 U.S. at 249. “If the  
2 evidence is merely colorable . . . or is not significantly probative . . . summary judgment  
3 may be granted.” Id. at 249–50. In reviewing the evidence “the court must draw all  
4 reasonable inferences in favor of the nonmoving party, and it may not make credibility  
5 determinations or weigh the evidence.” Reeves v. Sanderson Plumbing Prods. Inc., 530  
6 U.S. 133, 150 (2000).

7 **A. Exhaustion**

8 “Section 502 of ERISA entitles a participant or beneficiary of an  
9 ERISA-regulated plan to bring a civil action ‘to recover benefits due to him under the  
10 terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights  
11 to future benefits under the terms of the plan.’” Chappel v. Lab. Corp. of Am., 232 F.3d  
12 719, 724 (9th Cir. 2000) (quoting 29 U.S.C. § 1132(a)(1)(B)). Before a beneficiary may  
13 bring such a claim, though, “exhaustion, at least to the level of the trustees, is ordinarily  
14 required where an action seeks a declaration of the parties’ rights and duties under the  
15 [ERISA] plan.” Graphic Commc’ns Union, Dist. Council No. 2, AFL-CIO v.  
16 GCIU-Emp’r Ret. Benefit Plan, 917 F.2d 1184, 1187 (9th Cir. 1990) (emphasis in  
17 original) (citations and internal quotation marks omitted). Suits raising unexhausted  
18 claims are barred absent a showing that the relevant unexhausted plan provision is either  
19 unenforceable or invalid. Chappel, 232 F.3d at 724.

20 Plaintiffs’ argument in favor of exhaustion in this case is confined to three  
21 occasions: specifically, that “Group Health failed to (1) timely process and respond to  
22 Z.D.’s October 25, 2010 pre[-]service request for coverage of speech therapy; (2)  
23 institute any appeal or consideration of a pre-service speech therapy claim in response to  
24 Z.D.’s December 9, 2010 request to do so; and (3) timely respond to Z.D.’s September  
25 12, 2011 post-service claim for speech therapy benefits.”<sup>4</sup>

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26 <sup>4</sup> Accordingly, the Court does not address Defendants’ arguments as to other dates.

1 In response, Defendants raise three arguments. First, they contend that Plaintiff's  
2 "pre-service" requests were not true "pre-service" requests at all and that Group Health  
3 therefore had no obligation to respond. Second, they contend that Group Health did  
4 timely respond to the 2011 claim and that, even if it did not, it has since tendered  
5 payment, mooting any claim. Finally, it argues that Plaintiffs' administrative remedies  
6 would not have been be futile. The Court disagrees with each of Defendants' positions  
7 and finds that Plaintiffs are entitled to judgment as a matter of law. It thus GRANTS the  
8 motion (Dkt. # 43).

### 9 **1. Exhaustion of 2010 "Pre-Service" Claims**

10 The facts relevant to Plaintiffs' 2010 "pre-service" requests are straightforward  
11 and undisputed: On October 15, 2010, J.D. sent Group Health a letter that recounted its  
12 prior age-based denials of her requests for treatment for Z.D. and immediately added,  
13 "Please consider this letter to be an appeal of Group Health's denial of my requests for  
14 speech therapy and neurodevelopmental evaluation for my daughter." Dkt. # 45-1 at 18  
(emphasis in original).

15 She further noted that she had recently had her daughter evaluated again and had  
16 been told that she needed to "receive additional medically necessary speech therapy."  
17 Id. (emphasis omitted). She explained that she intended "to enroll Z.D. at Northwest  
18 Language and Learning for the recommended speech therapy" and stated: "I request  
19 that Group Health reconsider its exclusion of neurodevelopmental therapy coverage for  
20 my daughter and provide her with coverage for neuropsychological evaluation and  
21 speech therapy services. Both neurodevelopmental evaluation and speech therapy are  
22 medically necessary services to treat my daughter's developmental disabilities and  
23 communication disorder." Id. (emphasis in original).

24 In its response, Group Health did not address J.D.'s request for speech therapy,  
25 stating only that it had no record of having denied any claims arising from a distinct  
26 evaluation not at issue here. Id. at 23. J.D. was not dissuaded. She wrote back in a

1 certified letter dated December 9, 2010, stating bluntly that she considered Group  
2 Health’s non-response to her request for coverage to be a de facto denial of coverage.  
3 Id. at 25. She then immediately stated again: “Please consider this letter to be an appeal  
4 of Group Health’s denial of my requests for speech therapy and neurodevelopmental  
5 evaluation for my daughter.” Id. (emphasis in original).

6 Moreover, eliminating any reasonable objective potential for ambiguity,<sup>5</sup> she  
7 went on to explain that she had “enrolled Z.D. at Northwest Language and Learning for  
8 the recommended speech therapy” and then immediately stated again: “I request that  
9 Group Health reconsider its exclusion of neurodevelopmental therapy coverage for my  
10 daughter and provide her with coverage for neuropsychological evaluation and speech  
11 therapy services. Both neurodevelopmental evaluation and speech therapy are  
12 medically necessary services to treat my daughter’s developmental disabilities and  
13 communication disorder.” Id. (emphasis in original).

14 In the face of these plain requests for coverage and notices of appeal, Defendants  
15 argue simply that no response was required because Plaintiffs’ requests were not valid  
16 “pre-service” claims, as defined under ERISA. See Opp. (Dkt. # 54) at 15–18. They  
17 contend that ERISA places procedural requirements only on a “claim for a benefit under  
18 a group health plan with respect to which the terms of the plan condition receipt of the  
19 benefit, in whole or in part, on approval of the benefit in advance of obtaining medical  
20 care,” 29 C.F.R. § 2560.503-1(m)(2), and that, because the Plan does not require pre-  
21 approval of outpatient speech therapy like Z.D. was requesting, her requests did not  
22 constitute pre-service requests. Opp. (Dkt. # 54) at 15–18. Technically speaking, the  
23 Court agrees. J.D.’s letters would not appear to fall within the technical definition of  
24 “Pre-service claims” set forth in the regulation.

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24 <sup>5</sup> To be clear, the Court sees absolutely no factual basis from which to conclude that  
25 reasonable minds could disagree as to the import of J.D.’s correspondences. Her letters make it  
26 clear beyond any possibility for fairminded disagreement that she was requesting both coverage  
for future expected treatment at Northwest and reconsideration of prior denials.



1 Notably, however, that does not mean that the regulation contemplates that  
2 Defendants could merely sit on their hands in the face of her requests. Apart from the  
3 specific obligations attached to “pre-service claims,” the regulation precludes claim  
4 procedures from being “administered in a way, that unduly inhibits or hampers the  
5 initiation or processing of claims for benefits.” § 2560.503-1(b)(3). It goes on to  
6 specifically provide “that, in the case of a failure by a claimant or an authorized  
7 representative of a claimant to follow the plan’s procedures for filing a pre-service  
8 claim, within the meaning of paragraph (m)(2) of this section, the claimant or  
9 representative shall be notified of the failure and the proper procedures to be followed in  
10 filing a claim for benefits.” § 2560.503-1(c)(1)(i) (emphasis added). Compare  
11 § 2560.503-1(c)(1)(ii) (noting requirements), with Dkt. # 45-1 at 18 (naming “a specific  
12 claimant; a specific medical condition or symptom; and a specific treatment . . . for  
13 which approval is requested”).

14 As explained by the Department of Labor, which promulgated the regulation, “a  
15 group health plan that requires the submission of pre-service claims, such as requests for  
16 preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis  
17 for concluding that the inquirer is attempting to file or further a claim for benefits,  
18 although not acting in compliance with the plan’s claim filing procedures.” U.S.  
19 Department of Labor FAQs About the Benefits Claim Procedure Regulations (“DOL  
20 FAQs”), available at [http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html), at A-5  
21 (emphasis added). Rather, “the regulation requires the plan to inform the individual of  
22 his or her failure to file a claim and the proper procedures to be followed.” Id.; see  
23 Barboza v. Cal. Ass’n of Prof’l Firefighters, 651 F.3d 1073, 1079 (9th Cir. 2011)  
24 (deferring to the Secretary of Labor’s interpretation of § 2650.503-1 because “[w]hen  
25 evaluating conflicting interpretations of an administrative regulation, we are required to  
26 give ‘substantial deference’ to the agency’s interpretation of its own regulations”).

1 Thus, even assuming that J.D.’s letter was an inappropriate pre-service claim, the  
2 Court finds it beyond any possibility for fairminded disagreement that Group Health had  
3 “a basis” for concluding that J.D. was “attempting to file or further a claim for benefits.”  
4 Compare Dkt. # 45-1 at 18, with DOL FAQs, at A-5. Group Health therefore had an  
5 obligation to inform her of the shortcoming of her request—that, as Defendants now  
6 contend, it was not an appropriate pre-service claim—and of the proper procedure for  
7 filing a claim, i.e., either concurrently or post-service.<sup>6</sup> Compare § 2560.503-1(c)(1)(i),  
8 with Dkt. # 48-1 at 80 (noting that Group Health recognizes pre-service, concurrent, and  
9 post-service claims). Because it failed to do either, Plaintiffs’ claims are deemed  
10 exhausted. § 2560.503-1(l) (“In the case of the failure of a plan to establish or follow  
11 claims procedures consistent with the requirements of this section, a claimant shall be  
12 deemed to have exhausted the administrative remedies available under the plan and shall  
13 be entitled to pursue any available remedies under section 502(a) of the Act on the basis  
14 that the plan has failed to provide a reasonable claims procedure that would yield a  
15 decision on the merits of the claim.”).

16 Moreover, the fact that the Plaintiffs may not have filed a claim contemplated by  
17 § 2560.503-1(m)(2) does not mean that it was not a valid claim under the terms of the  
18 Plan itself. As § 2560.503-1(a) states, it “sets forth minimum requirements for employee  
19 benefit plan procedures pertaining to claims for benefits by participants and  
20 beneficiaries.” Id. (emphasis added). It does not preclude a Plan from providing greater  
21 protections. See Chappel, 232 F.3d at 724 (noting the distinction between rights and  
22 benefits accorded “by the statutory provisions of ERISA itself” and rights and benefits  
23 provided “by the contractual terms of the benefits plan”). And in this case, the Plan does

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24 <sup>6</sup> As Plaintiffs point out, Group Health is a fiduciary. The law does not permit it to  
25 simply sit on its hands while a beneficiary unsuccessfully attempts to “navigate the byzantine  
26 bureaucracy of a health carrier.” Mot. (Dkt. # 43) at 15. It had a duty to aid J.D. in her  
attempts to present a claim. See § 2560.503-1(c)(1)(i).

1 not expressly incorporate § 2560.503-1(m)(2)'s definition of or otherwise define "pre-  
2 service claim." It simply states:

3 D. Claims

4 Claims for benefits may be made before or after services are  
5 obtained. To make a claim for benefits under the Agreement, a  
6 Member (or the Member's authorized representative) must contact  
7 GHO Customer Service, or submit a claim for reimbursement as  
8 described below. Other inquiries, such as asking a health care  
9 provider about care or coverage, or submitting a prescription to a  
10 pharmacy, will not be considered a claim for benefits.

11 \* \* \*

12 GHO will generally process claims for benefits within the  
13 following timeframes after GHO receives the claims:

14 § Pre-service claims – within fifteen (15) days.

15 § Claims involving urgently needed care – within seventy-two  
16 (72) hours.

17 § Concurrent care claims – within twenty-four (24) hours.

18 § Post-service claims – within thirty (30) days.

19 Timeframes for pre-service and post-service claims can be  
20 extended by GHO for up to an additional fifteen (15) days.  
21 Members will be notified in writing of such extension prior to the  
22 expiration of the initial timeframe.

23 Dkt. # 56-2 at 6 (2010 Plan Benefit Booklet)<sup>7</sup>; accord Dkt. # 56-2 at 59 (2011 Plan  
24 Benefit Booklet); see also Dkt. # 56 at ¶ 4 (stating that the 2010 Contract was effective  
25 March 1, 2010, and the 2011 Contract was effective March 1, 2011).

26 Undoubtedly recognizing the lack of textual support for its litigation position,  
Defendants argue that Group Health nonetheless applies the ERISA definition of "pre-

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<sup>7</sup> The Court recognizes that the Supreme Court has distinguished between summary documents and Plan terms. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) ("[S]ummary documents, important as they are, provide communication with beneficiaries about the plan, . . . their statements do not themselves constitute the terms of the plan for purposes of § 502(a)(1)(B)." (emphasis omitted)). Noting that the "GHO Booklets" relied upon by the parties themselves state they are "not the contract itself," e.g., Dkt. # 56-2 at 2, 51, the Court directed the parties to file the actual contracts. Dkt. # 69. The parties subsequently filed those documents, pointing out, however, that the contracts themselves do not provide specific terms. Instead, they incorporate as Plan terms the provisions set forth in the GHO Booklets. E.g., Dkt. # 70 at 34 ¶ 1. The Court therefore treats the Booklet terms as the Plan terms.

1 service” claim. In support, they offer only the deposition testimony of Carroll Candace,  
2 one of their Rule 30(b)(6) deponents, arguing that she testified that “such claims need to  
3 be ‘contractually contingent’ on Group Health’s advance approval.” Opp. (Dkt. # 54) at  
4 18 (citing Dkt. # 48-1 at 80). The Court finds no support for that assertion.

5 The entirety of the relevant exchange between Ms. Carroll and Plaintiffs’ counsel  
6 was as follows:

7 Q: Do you also deal with situations where there is a pre-  
8 service request for authorization?

9 A: Yes.

10 Q: And that’s a situation where somebody is asking Group  
11 Health under the contract to approve benefits before the service has  
12 been provided, right?

13 A: Exactly.

14 Q: And that would then be sort of contractually contingent  
15 upon Group Health saying, yes, we bless this for payment in  
16 advance?”

17 A: Yes

18 Q: I tend to call those pre-service claims. Is that what Group  
19 Health calls them as well?

20 A: We call them – yes, I technically call them that, but Group  
21 Health doesn’t necessarily do that. That’s a health care reform term.  
22 So yes, I do use the word claim because ERISA uses the word claim.

23 \* \* \*

24 A: It’s a claim against benefit pre-service versus a claim to  
25 pay.

26 \* \* \*

Q: How does Group Health determine whether an individual  
is making a request for a pre-service claim?

A: The request comes in prior to the delivery of care.

Dkt. # 48-1 at 80 (emphasis added). As the whole conversation makes clear, Ms. Carroll  
not only fails to ever condition her understanding of the Plan term on the need for pre-  
approval, she expressly distinguishes Group Health’s understanding of its terms from the  
statutory definitions. Id. Furthermore, when asked point blank to identify how Group  
Health determines if “an individual is making a request for a pre-service claim,” she  
relies on only one condition: the timing of the claim. Id. Accordingly, the Court finds  
that Defendants have failed to offer any evidence sufficient to give rise to a genuine issue

1 as to the import of Group Health’s terms. Anderson, 477 U.S. at 249–50 (“If the  
2 evidence is merely colorable . . . or is not significantly probative . . . summary judgment  
3 may be granted.”). The October 25 letter served as “a claim for benefits under the  
4 Agreement” to which Group Health was obligated to respond.

5 And, of course, Group Health did respond. Moreover, it did so within the 15-day  
6 period set forth by the Plan for “processing” pre-service claims rather than the 30-day  
7 post-service review period, further reinforcing its understanding of its own terms’  
8 requirements. Dkt. # 45-1 at 23. It informed J.D. that it had no record of a denial and  
9 advised her that it had “forwarded her information to the claims department for  
10 processing.” Id. Dissatisfied with Group Health’s response, J.D. again wrote to appeal  
11 Group Health’s apparent de facto denial, wisely mailing her letter via certified mail.  
12 Group Health concedes it never responded to that letter, claiming that it never even  
13 received it. Opp. (Dkt. # 54) at 11. That claim is ultimately insufficient to overcome  
14 Plaintiffs’ exhaustion contention, however. Plaintiffs have presented evidence of both  
15 their mailing and Group Health’s receipt of their December 9, 2010 letter. Dkt. # 45-1 at  
16 25, 27–28. In response, Defendants merely assert non-receipt. And it is settled law that  
17 “[m]erely stating that the document isn’t in the addressee’s files or records . . . is  
18 insufficient to defeat the presumption of receipt.” Huizar v. Carey, 273 F.3d 1220, 1223  
n.3 (9th Cir. 2001).

19 Thus, in sum, the Court finds that, in addition to being able to claim the benefit of  
20 the automatic exhaustion provision of § 2560.503-1(l), Plaintiffs fulfilled their  
21 exhaustion obligations under the Plan itself. They both presented their 2010 claims to  
22 Group Health as the Plan terms required and subsequently appealed Group Health’s de  
23 facto denial. Accordingly, under either theory, the Court finds that Plaintiffs 2010 claims  
24 are exhausted. See Barboza, 651 F.3d at 1076 (“[T]he ‘applicability *vel non* of  
25 exhaustion principles is a question of law’ that ‘we consider . . . de novo.’”).

1                                   **2. Exhaustion of the 2011 Claim**

2           Next, the Court whether Plaintiffs exhausted their 2011 post-service claim.

3           Notably, Group Health tendered a check in partial payment of these claims on  
4 November 12, 2011—60 days after the claim was filed. See Dkt. # 57-2 at 4 (noting that  
5 Group Health paid \$609.00 of the \$810.00 claimed). The only amount it declined to pay  
6 was Plaintiffs’ Plan-designated co-pay amount. Accordingly, Defendants assert that  
7 there is no adverse benefit determination to appeal. Plaintiffs disagree. They assert that  
8 Group Health’s decision not to pay the entirety of the claim constituted an “adverse  
9 benefit determination.” Dkt. # 62 at 10–11. And, because Group Health did not provide  
10 them with notice of that adverse decision within 30 days of its receipt of their claim as  
11 required by § 560.503-1(f)(2)(iii)(B), the automatic exhaustion provisions of  
12 § 2560.503-1(l) were triggered.<sup>8</sup> The Court agrees.

13           While Defendants are correct in their assertion that “the regulation does not  
14 address the periods within which payments that have been granted must be actually paid  
15 or services that have been approved must be actually rendered,” DOL FAQs, at A-10,  
16 that is not the crux of Plaintiffs’ claim. To the contrary, Plaintiffs note that the regulation  
17 defines “adverse benefit determination” as any “failure to provide or make payment (in  
18 whole or in part).” § 2560.503-1(m)(4) (emphasis added). They argue that this includes  
19 even denials based on the imposition of co–pays, pointing out that this is the official  
20 position of the Department of Labor. DOL FAQs, at C-12 (answering the question, “If a  
21 claimant submits medical bills to a plan for reimbursement or payment, and the plan,  
22 applying the plan’s limits on co-payment, deductibles, etc., pays less than 100% of the  
23 medical bills, must the plan treat its decision as an adverse benefit determination?” in the

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24           <sup>8</sup> Plaintiffs also complain that Group Health has since indicated that it should not have  
25 paid any of the claim. See Dkt. # 48-1 at 50–61 (statement by one of Defendants’ Rule  
26 30(b)(6) deponents, Dean Solis, the acting associate of “Western Washington Health Plan  
Operations,” that Group Health should not have paid the claim). As a result, Plaintiffs rightly  
fear that Group Health could seek to clawback those funds at any time.

1 affirmative because “[i]n any instance where the plan pays less than the total amount of  
2 expenses submitted with regard to a claim, while the plan is paying out the benefits to  
3 which the claimant is entitled under its terms, the claimant is nonetheless receiving less  
4 than full reimbursement of the submitted expenses.”). The Court sees no reason not to  
5 defer to this interpretation. See Barboza, 651 F.3d at 1079.

6 Thus, the undisputed fact that Group Health did not pay the entirety of the claim  
7 constituted a partial denial of benefits and thus an adverse benefits determination.  
8 § 2560.503-1(m)(4). Accordingly, Group Health was required to inform Plaintiffs of this  
9 partial denial within 30 days of receiving the claim. § 560.503-1(f)(2)(iii)(B). Plaintiffs  
10 assert that it failed to do so, and, in response, Defendants essentially concede the point.  
11 Accordingly, the Court finds that Plaintiffs’ 2011-based claim is exhausted.

### 12 **3. Futility**

13 Because the Court finds that Plaintiffs exhausted both of the claims that are the  
14 subject of this motion, it does not reach the issue of futility.

15 Notably, though, the Court wishes to point out that Defendants’ position on  
16 futility—that administrative remedies may not have been futile because, despite the fact  
17 that the Plan does not permit coverage of non-restorative mental health therapies for  
18 individuals over the age of six,<sup>9</sup> Group Health sometimes paid them anyway—is  
19 troubling. As Plaintiffs point out, ERISA fiduciaries are not permitted to process claims  
20 on a whim. Rather, they are required to do precisely the opposite: “a fiduciary shall  
21 discharge his duties with respect to a plan solely in the interest of the participants and  
22 beneficiaries and . . . in accordance with the documents and instruments governing the

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23 <sup>9</sup> To be clear, the Court agrees with Plaintiffs that Defendants’ official position  
24 throughout this litigation has been that the Plan “required Group Health to deny  
25 neurodevelopmental therapy benefits for claimants over six years old,” Dkt. # 19 at 7, and that  
26 the record is replete with examples of Defendants asserting Group Health’s official position.  
See, e.g., Mot. (Dkt. # 43) at 21–27 (summarizing the many instances in which Group Health  
asserted its official position); Reply (Dkt. # 62) at 5–8 (same). Certainly, Defendants filed two  
motions premised on that position. Dkt. ## 7, 31. It is the entire reason this case exists.

1 plan insofar as such documents and instruments are consistent with the provisions of  
2 [ERISA].” 29 U.S.C. § 1104(a)(1)(D). Moreover,

3           The claims procedures for a plan will be deemed to be reasonable  
4           only if . . . [t]he claims procedures contain administrative processes  
5           and safeguards designed to ensure and to verify that benefit claim  
6           determinations are made in accordance with governing plan  
7           documents and that, where appropriate, the plan provisions have  
8           been applied consistently with respect to similarly situated claimants.

9 29 C.F.R. § 2560.503-1(b)(5).

10           Thus, in attempting to win the exhaustion battle, Defendants essentially concede  
11           the war by representing to this Court that Group Health deviates from the Plan’s terms to  
12           pay claims not permitted under the Plan contract. *E.g.*, *Opp.* (Dkt. # 54) at 23  
13           (“Notwithstanding Group Health’s policy limiting speech benefits to children under 7,  
14           the record shows that in Z.D.’s case Group Health paid speech therapy claims when she  
15           submitted them. . . . But even though those payments may have been ‘error’ in the sense  
16           that they were inconsistent with the TAF Contract, that ‘error’ has benefitted Plaintiffs  
17           every time . . .”). The Court has no choice but to treat this representation as a  
18           concession that Group Health is administering the Plan in an arbitrary and capricious  
19           fashion, i.e., that it is wholly failing to act as a fiduciary.

### 17           **B. Injunctive Relief**

18           The Court next considers Plaintiffs’ motion for “an order and judgment under  
19           ERISA clarifying that neurodevelopmental therapy to treat insureds with DSM-IV-TR  
20           mental health conditions may not be denied simply because the insured is over the age of  
21           six” and “enjoin[ing] Group Health from denying coverage for medically necessary  
22           neurodevelopmental therapy to treat insureds with DSM-IV-TR mental health conditions  
23           simply because the insured is over six years old.” *Mot.* (Dkt. # 44) at 7.

24           In opposition, Defendants raise three arguments: First, that “Group Health treats  
25           all neurodevelopmental disorders the same”; second, that “Plaintiffs’ own experience  
26           demonstrates the lack of an actual or imminent injury”; and third, that “the



1 Neurodevelopmental Therapies Mandate specifically permits terminating speech therapy  
2 at age 7.” Opp. (Dkt. # 53) at 15. The Court finds none persuasive. Rather, it finds that  
3 no genuine issue of material fact exists and that Plaintiffs are entitled to judgment as a  
4 matter of law under 29 U.S.C. § 1132(a)(1)(B) and (a)(3). It thus GRANTS Plaintiffs’  
5 motion (Dkt. # 44).

### 6 **1. Revisiting the Neurodevelopmental Therapies Mandate Issue**

7 The Court thinks it prudent to start with Defendant’s third argument: their third  
8 attempt to convince this Court that “the Neurodevelopmental Therapies Mandate  
9 specifically permits terminating speech therapy at age 7” and that the Mental Health  
10 Parity Act must therefore be interpreted in such a fashion that it does not require  
11 neurodevelopmental therapy coverage. Opp. (Dkt. # 53) at 15. As the Court stated in its  
12 prior resolution of this same argument,<sup>10</sup> the issue is not whether the Mandate requires  
13 coverage. Plainly it does not. Neither is there any dispute as to whether the Mental  
14 Health Parity Act repealed the Mandate. Again, plainly it did not. The only issue is  
15 whether the two statutes conflict, and as the Court has found on two separate occasions,  
16 they do not. Order (Dkt. # 30) at 8; Order (Dkt. # 36) at 2–3.

17 The previously enacted Mandate required “coverage for neurodevelopmental  
18 therapies for covered individuals age six and under.” RCW 48.44.450(1). It established  
19 a coverage floor, not a ceiling. Thus, the subsequently enacted Mental Health Parity Act  
20 merely imposed an additional, distinct requirement that mental health coverage “be  
21 delivered under the same terms and conditions as medical and surgical services.” H.B.  
22 1154, 59th Leg., Reg. Sess., ¶ 1 (Wash. 2005); see, e.g., Order (Dkt. # 30); Order (Dkt. #  
23 36). There does not exist even a close question as to whether there is a conflict between

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23 <sup>10</sup> The Court disagrees with Defendants’ representations regarding the “newness” of  
24 their argument. As before, Defendants contend that the Neurodevelopmental Therapies  
25 Mandate does not require coverage after an individual turns seven. As before, they argue that  
26 the Mental Health Parity Act did not repeal the Neurodevelopmental Therapies Mandate. And,  
as before, they contend that the two statutes conflict and that the Mandate trumps the Parity  
Act. There is nothing materially new about Defendants’ argument.

1 the statutes under established Washington law.<sup>11</sup>

2 In any case, as it appears that the message has yet to be received, the Court wishes  
3 to be clear: The coverage at issue in this case is the product of RCW 48.46.291, not the  
4 Neurodevelopmental Therapies Mandate. The Mandate continues to apply, requiring  
5 “coverage for neurodevelopmental therapies for covered individuals age six and under.”  
6 RCW 48.44.450(1). And while the Mandate no longer applies after a child turns seven,  
7 RCW 48.46.291 does. By its plain terms, it requires health maintenance organizations  
8 like Group Health to provide coverage for “mental health services” at increasing levels  
9 of parity with the coverage such entities provide for medical and surgical services. See  
10 RCW 48.46.291(2)(a)–(c).

## 11 **2. Statutory Treatment Requirements**

12 The Court next considers Defendants’ contention that, since January 2011, they  
13 have brought their policies in conformity with the Mental Health Parity Act and that an  
14 injunction is therefore unnecessary.<sup>12</sup> Opp. (Dkt. # 53) at 17. The Court disagrees.

15 The Court notes at the outset that Defendants paint a much rosier picture of their  
16 policies in their briefs than they apply in practice. For example, Defendants argue that  
17 they are in compliance with RCW 48.46.291(2)(c) because Group Health applies the  
18 same treatment limitations to mental health therapy services that it applies to all therapies  
19 services. Opp. (Dkt. # 53) at 16 (“Group Health imposes a treatment limit (age seven) on  
20 a limited set of therapies (speech therapy, physical therapy and occupational therapy)  
21 that treat medical and mental conditions alike.”). In actuality, however, Group Health  
22 does not apply an age-based treatment limitation across the board to all therapies related

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23 <sup>11</sup> A litany of Washington state courts have held the same. See, e.g., D.F. v. Wash.  
24 State Health Care Auth., No. 10-2-294007 SEA; Dkt. ## 74, 74-1 (listing decisions).

25 <sup>12</sup> The Court notes that Defendants mischaracterize Plaintiffs’ request. To be clear,  
26 Plaintiffs do not request that the Court find that an age limit is never appropriate under any  
circumstance. Opp. (Dkt. # 53) at 15–16. They assert only that Group Health cannot impose  
an age-based treatment limitation on neurodevelopmental therapies unless it generally imposes  
that same limit on “medical and surgical services.”

1 to medical and surgical services. See Dkt. # 56-2 at 82 (2011 terms).<sup>13</sup> It applies an age-

2  
3 <sup>13</sup> The Plan states:

4 **G. Rehabilitation Services.**

5 1. Rehabilitation services are covered as set forth in this section, limited  
6 to the following: physical therapy; occupational therapy; massage  
7 therapy; and speech therapy to restore function following illness, injury  
8 or surgery. Services are subject to all terms, conditions and limitations of  
9 the Agreement including the following:

10 a. All services require a prescription from either a MHCN or  
11 community physician and must be provided by a MHCN-approved or  
12 Community Provider rehabilitation team that may include medical,  
13 nursing, physical therapy, occupational therapy, massage therapy and  
14 speech therapy providers.

15 b. Under the Community Provider option, inpatient rehabilitation  
16 services must be authorized in advance by GHO.

17 c. Services are limited to those necessary to restore or improve  
18 functional abilities when physical, sensori-perceptual and/or  
19 communication impairment exists due to injury, illness or surgery.  
20 Such services are provided only when significant, measurable  
21 improvement to the Member's condition can be expected within a sixty  
22 (60) day period as a consequence of intervention by covered therapy  
23 services described in paragraph a., above.

24 d. Coverage for inpatient and outpatient services is limited to the  
25 Allowance set forth in the Allowances Schedule.

26 Excluded: inpatient Residential Treatment services; specialty  
rehabilitation programs; long-term rehabilitation programs; physical  
therapy, occupational therapy and speech therapy services when such  
services are available (whether application is made or not) through  
programs offered by public school districts; therapy for degenerative or  
static conditions when the expected outcome is primarily to maintain  
the Member's level of functioning (except as set forth in subsection 2.  
below); recreational, life-enhancing, relaxation or palliative therapy;  
implementation of home maintenance programs; programs for treatment  
of learning problems; any services not specifically included as covered  
in this section; and any services that are excluded under Section V.

**2. Neurodevelopmental Therapies for Children Age Six (6) and**

1 based limitation only to a narrow subcategory of medical and surgical services, namely,  
2 non-rehabilitative therapies—“therapy for degenerative or static conditions when the  
3 expected outcome is primarily to maintain the Member’s level of functioning,” as  
4 opposed to “restore function following illness, injury or surgery.” *Id.* (emphasis added).  
5 Thus, in reality, Group Health applies its age-based limitation to only a sub-category of a  
6 sub-category of its covered services: non-rehabilitative, therapy services.

7 In any case, the end result of Group Health’s actions is simple. As Defendants  
8 concede, “Group Health’s ‘official policy’” remains to terminate “neurodevelopmental  
9 therapies at age seven.” *Opp.* (Dkt. # 53) at 16 (“The plain language of the TAF  
10 Contract makes this equal treatment clear: the Neurodevelopmental Therapies benefit  
11 does not distinguish between types of conditions, but simply grants coverage for  
12 neurodevelopmentally disabled children (regardless of whether the neurodevelopmental  
13 disability is “mental” or “physical”), subject to common treatment limitations (e.g., no  
14 coverage after age six).”). They defend this practice by pointing to a single line of RCW  
15 48.46.291(2)(c): “Treatment limitations or any other financial requirements on coverage

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16 **Under.** Physical therapy, occupational therapy and speech therapy  
17 services for the restoration and improvement of function for  
18 neurodevelopmentally disabled children age six (6) and under shall be  
19 covered. Coverage includes maintenance of a covered Member in cases  
20 where significant deterioration in the Member’s condition would result  
21 without the services. Coverage for inpatient and outpatient services is  
22 limited to the Allowances set forth in the Allowances Schedule.

23 Excluded: inpatient Residential Treatment services; specialty  
24 rehabilitation programs; long-term rehabilitation programs; physical  
25 therapy, occupational therapy and speech therapy services when such  
26 services are available (whether application is made or not) through  
programs offered by public school districts; recreational, life-enhancing,  
relaxation or palliative therapy, implementation of home maintenance  
programs; programs for treatment of learning problems; any services not  
specifically included as covered in this section; and any services that are  
excluded under Section V.

Dkt. # 56-2 at 82 (some emphasis omitted).

1 for mental health services are only allowed if the same limitations or requirements are  
2 imposed on coverage for medical and surgical services . . . .” They contend that because  
3 Group Health essentially excludes all non-restorative “rehabilitative therapies related to  
4 medical and surgical services,” it may similarly exclude all coverage for similar non-  
5 restorative mental health or neurodevelopmental disorders. See Opp. (Dkt. # 53) at 17.

6 The Court finds two problems with this interpretation. First, Defendant’s  
7 interpretation ignores the full text of RCW 48.46.291. Even the subsection containing  
8 the clause relied upon by Defendants states plainly:

9 (2) All health benefit plans offered by health maintenance  
10 organizations that provide coverage for medical and surgical services  
11 shall provide:

12 (c) For all health benefit plans delivered, issued for delivery, or  
13 renewed on or after July 1, 2010, coverage for:

14 (i) Mental health services. The copayment or coinsurance for  
15 mental health services may be no more than the copayment or  
16 coinsurance for medical and surgical services otherwise  
17 provided under the health benefit plan. Wellness and  
18 preventive services that are provided or reimbursed at a lesser  
19 copayment, coinsurance, or other cost sharing than other  
20 medical and surgical services are excluded from this  
21 comparison. If the health benefit plan imposes a maximum  
22 out-of-pocket limit or stop loss, it shall be a single limit or  
23 stop loss for medical, surgical, and mental health services. If  
24 the health benefit plan imposes any deductible, mental health  
25 services shall be included with medical and surgical services  
26 for the purpose of meeting the deductible requirement.  
Treatment limitations or any other financial requirements on  
coverage for mental health services are only allowed if the  
same limitations or requirements are imposed on coverage for  
medical and surgical services . . . .

RCW 48.46.291(2)(c)(i) (emphasis added). And the statute defines “mental health  
services” as “medically necessary outpatient and inpatient services provided to treat  
mental disorders covered by the diagnostic categories listed in the most current version  
of the diagnostic and statistical manual of mental disorders, published by the American

1 psychiatric association,” with exceptions not at issue here. RCW 48.46.291(1). Thus,  
2 the Act plainly imposes a baseline coverage requirement requiring Group Health  
3 “provide . . . coverage for” Z.D.’s “medically necessary” treatment for her DSM-IV-TR  
4 mental health conditions without any regard for whether that treatment is restorative or  
5 non-restorative. RCW 48.46.291(2)(c)(i); see RCW 48.46.291(2)(a)(i), (b)(i).<sup>14</sup>

6 Second, Defendants’ focus on the final clause of subsection (c)(i) ignores the  
7 history and structure of the statute. As enacted, the statute is meant to impose  
8 increasingly stringent requirements on entities like Group Health every two years. RCW  
9 48.46.291(2)(a)–(c). Thus, the addition of the treatment limitation is not meant to  
10 weaken or supplant the baseline coverage requirement; it is meant to bolster it by further  
11 limiting the conditions an entity like Group Health can impose on its coverage of mental  
12 health conditions like Z.D.’s. Id. In short, the clause precludes Group Health from  
13 imposing precisely the sort of tailored limitations at issue here—limitations that would  
14 defeat the very purpose of the statute: providing coverage.

15 In sum then, the Court finds that RCW 48.46.291(2)(c)(i) requires Group Health  
16 to provide coverage for “medically necessary outpatient and inpatient services provided  
17 to treat mental disorders covered by the diagnostic categories listed in the most current  
18 version of the diagnostic and statistical manual of mental disorders, published by the  
19 American psychiatric association,” with those limited exceptions set forth in the statute,  
20 RCW 48.46.291(1). And it finds that the final clause of subsection (c)(i) only further  
21 precludes Group Health from imposing treatment limitations it does not generally  
22 “impose[] on coverage for medical and surgical services.” RCW 48.46.291(2)(c)(i).  
Accordingly, because Group Health does not exclude individuals over the age of six

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23 <sup>14</sup> This interpretation is also supported by the Washington Senate Bill Report for the  
24 Parity Act, which states: “**Background:** Current Washington law does not require health  
25 carriers to include mental health coverage in any benefit plan. . . . **Summary of Bill:**  
Beginning January 1, 2006[,] a health benefit plan that provides coverage for medical and  
26 surgical services must provide coverage for mental health services and prescription drugs to  
treat mental disorders.” Dkt. # 9 at 40–41.

1 from coverage for medical and surgical services or even impose an age-based limitation  
2 on its therapy coverage in general, it may not impose that limitation on non-restorative  
3 mental health therapy coverage.<sup>15</sup>

### 4 **3. Actual or Imminent Injury**

5 Finally, the Court turns to Defendants' contention that Plaintiffs cannot show a  
6 likelihood of irreparable injury.

7 The crux of Defendants' position is, again, that regardless of Group Health's  
8 actual policies, they may in fact pay future claims.<sup>16</sup> As Defendants state: "Apart from  
9 Group Health's policies, Plaintiffs' actual experience with Group Health's claims  
10 practice belies their claim that Group Health 'systematic[ally] violates . . . plan terms' or  
11 will do so in the future." See Opp. (Dkt. # 53) at 17.

12 First and foremost, this contention is patently deficient as a matter of law. As  
13 stated, ERISA requires "a fiduciary [to] discharge his duties with respect to a plan solely  
14 . . . in accordance with the documents and instruments governing the plan." 29 U.S.C.  
15 § 1104(a)(1)(D). Accordingly, it is no excuse for Defendants to represent that the Plan  
16 precludes the coverage sought, and yet simultaneously argue that, "[w]hile there may be  
17 some discrepancy between Group Health's practice and its official policy toward  
18 neurodevelopmental therapies, . . . its practice has changed in Plaintiffs' favor,  
19 suggesting a strong likelihood of future coverage." Opp. (Dkt. # 53) at 20. The Court  
20 will not leave Plaintiffs at the mercy of Group Health's plainly arbitrary application of its  
21 own Plan terms or its ever-evolving understanding of Plaintiffs' entitlement to coverage.

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22 <sup>15</sup> Accordingly, it would also seem that Group Health cannot condition coverage on the  
23 availability of treatment through "programs offered by public school districts." Cf. Dkt. # 56-2  
24 at 82 (2011 terms).

25 <sup>16</sup> Defendants also contend that Plaintiffs conceded that they have no plans to start  
26 speech therapy again. Opp. (Dkt. # 53) at 19. As they concede, though, that is no longer the  
case. Id. Moreover, as the entirety of the record in this case makes clear, every doctor who has  
evaluated Z.D. has recommended that she get treatment. And her parents' desire to follow  
doctor's recommendations is the impetus for this case.

1           Moreover, Group Health’s boots on the ground clearly do not share the same  
2 impression as its lawyers as to Plaintiffs’ likelihood of future coverage. As one of its  
3 regional managers, Tomi McVay, testified in her role as Rule 30(b)(6) deponent:

4           Q: So if a person comes to you who is age seven, has a  
5 neurodevelopmental problem, disorder—let’s go even further and  
say that they have diagnosed DSM-IV-TR diagnoses as well.

\* \* \*

6           The person then comes to you and says, “I understand that I’m not  
7 covered under the neurodevelopmental benefit because I’m age  
seven, am I covered under the rehab benefit?”

8           And the first thing you do [is] determine whether they are  
trying to improve their function or restore function? Is that what  
9 goes on clinically?

A: I do an evaluation and I send it to clinical review.

10          Q: And if the evaluation concludes that they’re seeking  
11 speech therapy to not just restore previous function but to improve  
function, your expectation is that Group Health would determine that  
to be not medically necessary?

\* \* \*

A: Typically, yes.

13          Q: And that’s your current understanding up to today, is that  
correct?

14          A: Yes. . . .

15 Dkt. # 64 at 27. Furthermore, she goes on to note that there have been “[l]ess than  
16 seven” cases in which treatment has continued to be covered after the individual turned  
17 seven. Id. It thus appears that both Defendants’ policies and its practices do not favor  
18 Plaintiffs’ chances of obtaining the coverage to which she is entitled absent an injunctive  
19 order—acutely demonstrating the need for the Court “to clarify [Plaintiffs’] rights to  
20 future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B).

\* \* \*

21           In sum, the Court finds (1) that RCW 48.46.291 is effective against Group Health,  
22 (2) that neither Group Health’s policies nor its practices adhere to the statute’s mandates,  
23 and (3) that Plaintiffs have more than demonstrated a substantial likelihood of harm  
24 absent injunctive relief. Accordingly, the Court GRANTS Plaintiffs’ motion for  
25 declaratory and injunctive relief under § 1132(a)(1)(B) and (a)(3). The Court ORDERS




1 Defendants to cease denying coverage for medically necessary neurodevelopmental  
2 therapy to treat insureds with DSM-IV-TR mental health conditions simply because the  
3 insured is over six years old. Moreover, the Court ORDERS Defendants to cease their  
4 application of any treatment limitations that are not generally “imposed on coverage for  
5 medical and surgical services.” RCW 48.46.291(2)(c)(i). The Court will not look kindly  
6 on failures to immediately implement its directive.

### 7 **III. CONCLUSION**

8 For all of the foregoing reasons, the Court GRANTS Plaintiffs’ “Motion for  
9 Summary Judgment re: Exhaustion of Administrative Remedies” (Dkt. # 43) and  
10 “Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and  
11 Injunctive Relief under ERISA” (Dkt. # 44).

12 Plaintiffs exhausted their 2010 and 2011 claims and have demonstrated as a  
13 matter of law that Group Health’s policies and its actions fail to comport with the plain  
14 requirements of Washington’s Mental Health Parity Act. Accordingly, they are entitled  
15 to declaratory relief. Moreover, because they have demonstrated a strong likelihood of  
16 future irreparable injury absent injunctive relief, the Court ORDERS Defendants to  
17 immediately cease denying coverage for medically necessary neurodevelopmental  
18 therapy to treat insureds with DSM-IV-TR mental health conditions simply because an  
19 insured is over six years old. Defendants must immediately cease their application of  
20 any treatment limitations that are not generally “imposed on coverage for medical and  
21 surgical services.” RCW 48.46.291(2)(c)(i).

22 DATED this 1st day of June, 2012.

23   
24 Robert S. Lasnik  
25 United States District Judge