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U.S. COURT OF APPEALS

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UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

OKSANA B.; ALEXANDER B.; A.B., Plaintiffs - Appellees, v. PREMERA BLUE CROSS; TABLEAU SOFTWARE INC EMPLOYEE BENEFIT PLAN; SALESFORCE.COM HEALTH AND WELFARE PLAN, Defendants - Appellants.	Nos. 24-560, 24-757 D.C. No. 2:22-cv-01517-MJP MEMORANDUM[*]

Appeal from the United States District Court
for the Western District of Washington
Marsha J. Pechman, District Judge, Presiding

Argued and Submitted June 9, 2025
San Francisco, California

Before: S.R. THOMAS and M. SMITH, Circuit Judges, and RAYES,[**] District Judge.

[*] This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

[**] The Honorable Douglas L. Rayes, United States District Judge for the District of Arizona, sitting by designation.

Premera Blue Cross ("Premera") appeals the district court's judgment and award of attorneys' fees in favor of A.B., a minor, and his parents (collectively, "the Family") in this Employee Retirement Income Security Act ("ERISA") case under A.B.'s father's insurance plan ("the Plan"). We have jurisdiction pursuant to 28 U.S.C. § 1291. "[B]ecause the Plan grants discretionary authority to [Premera], we review [Premera's] benefits decision for an abuse of that discretion." *Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 928–29 (9th Cir. 2012). Because the parties are familiar with the facts and history of this case, we need not recount them here. We affirm in part, reverse in part, vacate in part, and remand.

I

Premera did not abuse its discretion by denying the Second Nature claim. Second Nature is a self-described "wilderness program." It provides "wilderness family therapy" and "wilderness therapy." The Plan excludes coverage for "wilderness . . . programs or activities." On those facts, it was not an abuse of discretion to determine that Second Nature is excluded under the Plan.

Premera also did not fail to provide a meaningful dialogue when denying the Second Nature claim. ERISA requires plan administrators, when denying a claim for benefits, to explain that denial and provide information about further appeals "in a manner calculated to be understood by the claimant." 29 C.F.R.

§ 2560.503-1(g)(1); *see also Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) (terming this the "meaningful dialogue" requirement). When a plan administrator denies a claim without a rational explanation or without acknowledging an argument by the claimant, it violates this requirement. *Booton*, 110 F.3d at 1463. When a plan administrator denies a claim based on an absence of evidence or explanation, but does not say in plain language what additional evidence or explanation it needs, it violates this requirement. *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 680 (9th Cir. 2011).

Premera's communication satisfied that requirement because it provided a rational explanation for the denial: Second Nature is a wilderness program, and wilderness programs are excluded. The Family never directly challenged that explanation, so Premera did not owe any additional response. Although Premera's level II denial said "wilderness *therapy*" is excluded rather than "wilderness . . . programs," that error was harmless because Premera repeatedly used the correct Plan language in its other levels of review and because wilderness therapy can be a subset of wilderness programs.

II

A

The district court correctly concluded that Premera violated ERISA by denying the Catalyst claim. Premera had at least two meaningful dialogue failures related to the Catalyst claim.

First, Premera never acknowledged or responded to the Family's argument that nothing had changed between Premera's decision to cover the first month of Catalyst and its subsequent denial of coverage. The Family's level I appeal argued that Premera had granted coverage for the first month of Catalyst, and so should continue granting coverage. ERISA obligated Premera to respond to the Family's argument. *See Booton*, 110 F.3d at 1463; *see also Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 871 (9th Cir. 2008) (holding that when an administrator had paid a participant disability benefits for a year, that "suggest[ed]" the participant was in fact disabled).

Second, Premera did not explain why the Family's medical evidence, recommendations from two therapists who treated A.B., was insufficient to show the medical necessity of residential treatment. The Family proffered this medical evidence in its level I appeal and argued it showed medical necessity. Premera was

thus obligated to respond to that evidence and argument. Its failure to do so was a meaningful dialogue failure. *See Booton*, 110 F.3d at 1463.

B

However, the proper remedy for this ERISA violation is to remand the Catalyst claim to Premera for reconsideration, rather than immediately awarding benefits. "Once a court finds that an administrator has acted arbitrarily and capriciously in denying a claim for benefits, the court can either remand the case to the administrator for a renewed evaluation of the claimant's case, or it can award a retroactive reinstatement of benefits." *Demer v. IBM Corp. LTD Plan*, 835 F.3d 893, 907 (9th Cir. 2016) (quoting *Cook v. Liberty Life Assurance Co. of Bos.*, 320 F.3d 11, 24 (1st Cir. 2003)). Where an administrator fails to explain a denial, and "the record does not clearly establish that [the administrator] should necessarily have awarded [the claimant] benefits," then remand to the administrator for renewed evaluation is the proper remedy. *Id.* In contrast, "reinstatement of benefits is appropriate in ERISA cases where . . . 'but for [the insurer's] arbitrary and capricious conduct, [the insured] would have continued to receive the benefits' or where 'there [was] no evidence in the record to support a termination or denial of benefits.'" *Id.* (alterations in original) (quoting *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th Cir. 2001)).

Here, although Premera abused its discretion by denying the Catalyst claim, this record does not clearly establish that the Family was entitled to coverage of that claim. The Family's primary evidence for medical necessity consists of medical recommendations by two therapists who treated A.B. But there was a conflicting recommendation from another medical professional, the independent reviewer at the level I appeal. Moreover, there were reasons to discount the therapists' recommendations: neither had treated A.B. since his admission to Catalyst, so neither could say whether he had improved there. And one recommended a "residential or therapeutic boarding school setting," not necessarily medical treatment as comprehensive as at Catalyst. Thus, this record suggests, but does not conclusively establish, that A.B.'s stay at Catalyst was medically necessary.

It is also not conclusive that Premera had decided to cover A.B.'s first month at Catalyst. That "suggests" that treatment at Catalyst was medically necessary within the meaning of the Plan, *see Saffon*, 522 F.3d at 871, but it is not conclusive as to that determination. Premera could still rationally deny the continued stay as medically unnecessary, even with no change in A.B.'s condition, if Premera conceded that it covered the first month in error.

In sum, the Family has made a strong showing that it is entitled to coverage for the Catalyst claim. However, given the factual disputes, on remand, the district court should remand the Catalyst claim to Premera for reconsideration. *Demer*, 835 F.3d at 907. We express no view on how Premera should decide that claim or on what additional evidence the Family could provide that would conclusively entitle it to coverage.

III

Because the district court's grant of attorneys' fees depended on determinations that we reverse, we vacate the district court's grant of attorneys' fees and remand for the district court to conduct that analysis anew.

IV

In sum, we reverse the Second Nature ERISA violation; affirm the Catalyst ERISA violation, but reverse the Catalyst benefit award; vacate the attorneys' fees award; and remand for further proceedings. Each side shall bear its or their own costs on appeal.

AFFIRMED IN PART, REVERSED IN PART, VACATED IN PART, AND REMANDED.