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Communication Breakdown:

By Mike Adams

"Meaningful Dialogue" After *D.K.*

"What we've got here is failure to communicate."

COOL HAND LUKE (WARNER BROS. 1967)

> "A failure to communicate a denial to the claimant consistent with ERISA's requirements can lead to judicial invalidation, even if the decision to deny benefits is correct."

When adjudicating a claim for benefits, an employee benefit plan or its administrator will understandably devote substantial attention to *what* the decision will be—that is, whether to grant or deny the claim. But plans and administrators alike would do well to remember the immortal lines that Strother Martin's captain delivers to Luke and the rest of the chain gang because how they communicate a decision denying benefits is every bit as important as the decision itself. A failure to communicate a denial to the claimant consistent with ERISA's requirements can lead to judicial invalidation, even if the decision to deny benefits is correct.

Every ERISA practitioner should know that ERISA entitles participants and beneficiaries to a "reasonable opportunity" for a "full and fair review" of any denied claim for benefits. 29 U.S.C. § 1133. Courts have found that this calls for a "meaningful dialogue" between the plan and the claimant. Although these requirements might sound procedural in nature, they are not. As one appellate court recently put it, "[w]e cannot overstate the importance of the fiduciary's duty to engage in a good faith meaningful dialogue under the plan. Failure to do so represents an independent basis to overturn a plan administrator's denial of benefits." *Dwyer v. United Healthcare Ins. Co.*, 115 F.4th 640, 650 (5th Cir. 2024) (internal quotations omitted).

Over the last few years, courts have not shied away from overturning denials of benefits, even under an arbitrary-and-capricious standard of review, for failure to engage in a meaningful dialogue with claimants. Some courts have given teeth to these requirements, going through denial letters with a fine-toothed comb to make sure that they comply. Consistent with their fiduciary obligations to safeguard plan assets, administrators and plans alike should be aware of how recent decisions have interpreted and applied these requirements to avoid having otherwise valid denials overturned.

This article proceeds in four parts. First, the article discusses ERISA's full-and-fair-review requirement, which gives rise to the "meaningful dialogue" standard.

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Second, the article looks at how recent decisions, in particular *D.K. v. United Behavioral Health*, 67 F.4th 1224 (10th Cir. 2023), cert. denied 144 S. Ct. 808 (2024), have interpreted the "meaningful dialogue" standard when evaluating whether denial notices comply with ERISA. Third, the article examines whether D.K. and similar cases are as impactful as some, particularly members of the plaintiff's bar, believe. And fourth, the article offers some tips on how to draft denial notices that satisfy ERISA's requirements as interpreted by D.K. and like cases.

THE STATUTORY AND REGULATORY ORIGINS OF THE "MEANINGFUL DIALOGUE" STANDARD

The "meaningful dialogue" standard springs from ERISA's full and fair review requirement. It will be helpful to briefly review the statutory and regulatory bases of the full and fair review requirement, and what that requirement entails. Section 503 of ERISA states:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, **setting forth the specific reasons for such denial,** written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for **a full and fair review** by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133 (emphasis added). The Department of Labor ("DOL") has promulgated regulations concerning the contents of the denial notices contemplated by Section 503. When benefits are denied, those regulations require the plan administrator to provide "[t]he specific reason or reasons for the adverse determination" and "the specific plan provisions on which the determination is based." 29 C.F.R. § 2560.503-1(g)(1)(i), (ii). If benefits are denied because the services are not medically necessary, the beneficiary is entitled to "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request." Id. § 2560.503-1(g)(1)(v)(B). A full and fair review of a denial must therefore include "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of the evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 893-94 (10th Cir. 1988).

The "meaningful dialogue" requirement originates from the Ninth Circuit's discussion of the DOL regulations in a case called *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461 (9th Cir. 1997). In that case, a horse kicked the claimant in the mouth, leaving her four front teeth severely damaged. The claimant's policy excluded ordinary dental work, but it did cover work required "on account of accidental injury to natural teeth." Id. at 1462. Dentists worked on both her injured front teeth and uninjured back teeth. The crux of the dispute was whether the claimant's policy covered the work on her uninjured back teeth, which, according to claimant's dentists, was necessary because her front teeth had to be splinted to her back teeth, and the back teeth had to be prepared to support the splint through a variety of procedures. The administrator denied the claim for work on the claimant's back teeth on the grounds that the back teeth were not injured. Claimant countered that the question was not whether her back teeth were injured, but rather whether the work on her back teeth was necessitated by injury to her natural teeth. Several rounds of correspondence failed to persuade the administrator to change its position. The administrator's own consulting dentist suggested that additional medical information might help resolve the claim, but the administrator did not request it.

Consistent with their fiduciary obligations to safeguard plan assets, administrators and plans alike should be aware of how recent decisions have interpreted and applied these requirements to avoid having otherwise valid denials overturned.

Eventually, the district court granted summary judgment in favor of the plan.

The Ninth Circuit reversed, finding that the administrator's denial letters did not comply with the DOL regulations. The Ninth Circuit explained that "[i]n simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." Id. at 1463. The administrator's denial letters didn't cut the mustard because they failed to provide a rational explanation for the denial of benefits. They didn't acknowledge the claimant's argument that her back teeth needed work on account of the injury to her front teeth. More problematic in the eyes of the Ninth Circuit, the administrator failed to ask for more information that its own dental consultant suggested might help the claimant to substantiate her claim. This led to the administrator making a "blindfolded" benefits decision, which amounted to an abuse of discretion that resulted in reversal. Id. at 1465.

D.K. V. UNITED BEHAVIORAL HEALTH LEADS TO FRESH SCRUTINY OF DENIAL LETTERS

In 2023, the Tenth Circuit decided *D.K. v. United Behavioral Health*, 67 F.4th 1224 (10th Cir. 2023), cert. denied 144 S. Ct. 808 (2024), a case that the plaintiff's bar says marks a paradigm shift in how the full and fair review requirements—and in particular the "meaningful dialogue" standard—are applied to denial letters.

The facts of *D.K.* were as follows. A.K., a middle schooler, struggled with suicidal ideation for many years and attempted suicide numerous times, resulting in frequent emergency room visits and inpatient hospitalizations. A.K.'s physicians recommended long-term residential treatment to help her develop necessary coping skills. The administrator initially approved three months of long-term residential treatment, but denied further coverage. A.K.'s parents appealed. Their appeal included letters from three medical professionals opining that A.K. required long-term residential treatment. The administrator initially acknowledged that A.K. required residential treatment, but denied the appeal on grounds that A.K.'s plan excluded such treatment. This was a mistake based on a misreading of the plan, which in fact did not exclude long-term residential treatment. A second reviewer repeated the error, again noting that A.K. appeared to require long-term residential treatment. Neither the first nor the second reviewer denied benefits on grounds that A.K.'s long-term residential treatment was not medically necessary.

That changed following another appeal by A.K.'s parents. This time, A.K.'s parents argued that the administrator had misread the policy and enclosed a fourth letter from a medical professional opining that A.K.'s premature discharge would be highly risky. At that point, the administrator recognized that A.K.'s policy did not exclude benefits for long-term residential treatment. The administrator nonetheless denied A.K.'s appeal because medical necessity was not met, citing A.K.'s lack of injurious behavior while enrolled in long-term residential treatment and a stable diagnosis. A.K.'s parents appealed again, arguing that the administrator's denial rationales had shifted and enclosed a fifth letter from a medical professional supporting the medical necessity of A.K.'s continued long-term residential treatment. In this appeal, A.K.'s parents requested clarification as to the weight given to the medical opinions of various treating professionals, clarification on how medical necessity could not be found, and evidence of the clinical references relied on for the denial. The administrator denied this appeal as well.

A.K.'s parents appealed for a fourth time and requested an external review. The third-party reviewer agreed with the administrator's decision to deny benefits, noting the various medical evidence provided and the prior denial letters and finding that there was no evidence that A.K.'s continued stay in long-term residential care was the safest and most effective level of care. The reviewer determined that it was not medically necessary for A.K. to remain in residential treatment.

A.K.'s parents filed suit—sadly, A.K. passed away while the appeal was pending—and the case eventually made its way to the Tenth Circuit. The Tenth Circuit held that the administrator acted arbitrarily and capriciously for two reasons.

First, the Tenth Circuit found that the administrator failed to engage with the opinions of A.K.'s treating physicians, who recommended long-term residential treatment. By not providing an explanation for rejecting or not following the opinions of A.K.'s treating physicians, the administrator effectively "shut its eyes" to readily available medical information. D.K., 67 F.4th at 1237. "This is the core of meaningful dialogue: if benefits are denied and the claimant provides potential counterevidence from medical opinions,

the reviewer must respond to the opinions." *Id*. at 1241.

Second, the administrator's denial letters failed to explain the denial by applying the terms of the plan to A.K.'s medical records. "An administrator's explanation for a denial provided during a full and fair review cannot merely reference the claimant's evidence." Id. at 1242. In referring to a claimant's medical records, administrator statements may not be conclusory, and any health conclusions must be backed up with reasoning and citations to the record. *Id*.

Turning to the contents of the administrator's denial letters, the Tenth Circuit found that they contained only four statements that specifically referenced A.K.'s condition: (1) that her diagnosis and medications did not change extensively from admission to the long-term residential facility to the date of review; (2) that the record lacked evidence of self-injurious behavior during A.K.'s admission to long-term residential care; (3) that A.K. had "treatment resistant behaviors"; and (4) that A.K. "continued to act out behaviorally." Id. The administrator did not back up any of these statements with citations to the record. And—critical to the Tenth Circuit's finding that the administrator's decision was arbitrary and capricious—the administrator's statements "could have also supported a finding that A.K. needed ongoing treatment, but the reviewers simply concluded that they indicated A.K. could be treated at a lower level of care." *Id*.

The administrator raised several arguments in defense of its process, all of which the Tenth Circuit rejected.

First, the administrator argued that it was not obligated to engage with the opinions of A.K.'s treating physicians, relying on *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 831 (2003), in which the Supreme Court stated that an administrator is not required to defer to the opinions of a treating physician. But, as the Tenth Circuit pointed out, Black & Decker also says that a reviewer may not arbitrarily refuse to credit the opinions of treating physicians if they constitute reliable evidence from the claimant. *Id*. at 834. Thus, if the administrator "shut [its] eyes" to the opinions of A.K.'s treating physicians, it acted arbitrarily and capriciously. D.K., 67 F.4th at 1237.

Second, the administrator argued that ERISA imposes less stringent requirements on communications relating to medical claims (as opposed to disability claims), and that it complied with these looser regulations. The Tenth Circuit recognized textual differences in the ERISA disability and ERISA medical regulations, but disagreed that those differences absolved the administrator of providing a full and fair review for health benefit claims. Id. at 1238. Furthermore, even if those regulations could be read as installing a lower floor for communications relating to medical claims, the administrator still had a fiduciary obligation to provide a full and fair review through a reasonable process, consistent with the plan. *Id*. at 1239.

Third, the administrator argued that its internal notes proved that it engaged with the opinions of A.K.'s physicians. The Tenth Circuit rejected that argument, reasoning that administrators cannot partake in a dialogue, much less a meaningful dialogue, without communicating the basis for denial to the claimant. *Id*. at 1241. Courts cannot credit information that the administrator does not share with the claimant. Id.

Having found that the administrator acted arbitrarily and capriciously in denying A.K.'s claim for benefits, the Tenth Circuit affirmed the district court's entry of summary judgment in plaintiff's favor and its order of benefits.

Why do some believe that *D.K*. marks a seismic change in the way denial letters are evaluated? Its champions tout it as holding that administrators are required to engage with and respond to claimants' evidence, and that it is not sufficient to simply rely on another medical professional's opinion, or even to reference the claimant's evidence.

It is true that a number of courts have adopted D.K.'s scrutinization of denial letters since the Tenth Circuit filed the case in 2023. And some of those courts invalidated denial letters on grounds that administrators failed to engage with and respond to claimants' evidence, or made conclusory findings that were not backed up with citations to the record.

In *Dyer v. United Healthcare Ins. Co.*, 115 F.4th 640 (5th Cir. 2024), the Fifth Circuit applied a similar analysis to reverse an administrator's denial of partial hospitalization benefits. The claimant's minor daughter E.D. suffered from anorexia nervosa, for which she received treatment at a residential facility. The administrator approved full hospitalization benefits for E.D., but later reduced coverage to partial hospitalization and then terminated coverage entirely, over the objections of E.D.'s doctors. The Fifth Circuit found that the administrator's denial was procedurally deficient because its denial letter

failed to state the specific reason or reasons for the adverse determination and the specific plan provisions on which the determination was based. Id. at 650.

Earlier this year, in *T.E. v. Anthem Blue Cross*, 2026 U.S. App. LEXIS 1600 (6th Cir. Jan. 22, 2026), the Sixth Circuit found an administrator's denial was arbitrary and capricious when viewed through a lens similar to the one used in D.K. In T.E., a minor, C.E., had mental health issues, including ADHD, anxiety, and autism. After failed treatment attempts, C.E. was enrolled in a residential treatment center. The administrator approved 21 days of coverage based on C.E.'s mood and executive functioning issues. During this stay, the administrator's case manager found that C.E.'s continued treatment was medically necessary because C.E. had severe executive functioning issues and difficulty self-regulating. A few weeks later, and notwithstanding the lack of a documented change in C.E.'s condition, the case manager found that she could not authorize additional treatment despite the treatment facility's request that C.E.'s stay continue. The administrator issued a denial letter explaining that C.E.'s continued stay at the residential treatment facility was not medically necessary because his condition had improved, he remained safe, he remained mentally stable, and a family support session had been completed that did not show C.E. to be a danger to himself or others.

C.E.'s father, T.E., appealed. To support the appeal, he highlighted excerpts from C.E.'s medical records and submitted three opinions from C.E.'s treating health professionals. The administrator referred T.E.'s appeal to a physician for review. The physician concluded that C.E. did not meet the criteria set forth in the MCG Guideline for Residential Behavioral Health Level of Care, Child or Adolescent, and that the denial was therefore appropriate. T.E. appealed a second time. The administrator submitted T.E.'s second appeal to a different physician for review. That physician reviewed C.E.'s records and concluded that they did not show the need for continued stay at a residential treatment facility. No further explanation was provided. The administrator sent another denial letter with the same denial rationale used in its prior letter, concluding that C.E. was no longer at risk for serious harm requiring 24-hour care.

Using a three-factor test, the Sixth Circuit found that the administrator's denial was procedurally arbitrary and capricious. In the Sixth Circuit's eyes, the administrator failed to consider relevant evidence by ignoring the opinions of C.E.'s treating clinicians, and failing to explain its disagreement with them. The administrator also selectively reviewed the remainder of the medical evidence, and it did not adequately explain its coverage decision or its change from its earlier benefits ruling in which it determined that C.E. required treatment in a residential facility.

The administrator made several unavailing counterarguments. It argued that it expressly cited the opinions of C.E.'s treating physicians, but the Sixth Circuit found more was required. An administrator must "address the relevant aspects of a treating doctor's opinion head on, not merely cite other, collateral portions of that opinion." T.E., 2026 U.S. LEXIS 1600, at *15. The administrator also argued that an administrator ignores evidence only if it makes a statement that contradicts evidence in the record. The Sixth Circuit didn't buy this argument either. "An administrator can impermissibly ignore evidence even without committing misrepresentations or mistakes." Id. at *16. The Sixth Circuit found that the administrator, and the administrator's reviewers, cherry-picked favorable evidence while ignoring unfavorable evidence—the "hallmark of arbitrary-and-capricious decision-making." Id. at *19.

These are two of the more high-profile cases that followed D.K.'s framework and held that denial letters failed to satisfy ERISA's requirements. There are, of course, others. See, e.g., S.F. v. CIGNA Health & Life Ins. Co., Case No. 1:22-cv-68-HCN, 2025 U.S. Dist. LEXIS 161659 (D. Utah Aug. 19, 2025); K.A. v. United Healthcare Ins. Co., 764 F. Supp. 3d 763 (N.D. Ill. 2025). And there are many more cases in which claimants have argued for an expansive reading of D.K. In the next section, we consider whether an expansive reading is warranted.

THE LIMITS OF D.K.'S REACH

There are reasons to question whether D.K. and similar cases really mark a change in the way courts analyze denial letters for compliance with ERISA's full and fair review requirements. D.K. involved bad facts, and bad facts make bad law. In addition, although courts have not limited application of D.K.'s analysis to specific factual circumstances, it is worth noting that D.K., Dyer, T.E., S.F., and K.A. all involved claims for coverage of stays at residential facilities to treat mental illnesses. All of this is to say that compliance with ERISA's

full-and-fair review requirements depends on the unique facts of each case, and that D.K. and similar cases can properly be read as confined to their particular facts and circumstances. This is underlined by cases that have distinguished D.K.

Perhaps the strongest argument for a narrow construction of D.K. comes from E.W. v. Health Net Life Ins. Co., 86 F.4th 1265 (10th Cir. 2023), a case in which the Tenth Circuit itself distinguished D.K. Like D.K., E.W. involved a claim for residential treatment of a mental illness. I.W. received treatment at a residential facility. Five months into I.W.'s treatment at the facility, the administrator of I.W.'s benefits plan determined continued treatment was not medically necessary under InterQual criteria, which required symptoms within the past week to qualify for continued residential treatment. The administrator's denial letters stated that I.W. did not exhibit any of the required symptoms within the relevant timeframe. On appeal, claimants did not argue that the administrator's denials conflicted with any particular statutory or regulatory provision delineating the requirements of full and fair review, but they did argue that the administrator failed to conduct a full and fair review because it did not explain the reasons underlying its determinations, as D.K. required. E.W., 86 F. 4th at 1299-1300.

The Tenth Circuit declined to extend D.K. to the circumstances presented in E.W. because the administrator's letters in E.W. were not deficient. The denials cited to the specific diagnostic criteria and explained the administrator's decision to deny coverage with application of the facts to those criteria. Id. at 1301. Unlike in D.K., the administrator's analysis could not also have supported a finding that ongoing treatment was medically necessary. Moreover, the administrator's denial did not require extensive citations to the medical records because the administrator derived its findings primarily from the absence of record evidence supporting continued coverage. There was little opportunity for the administrator to support its decision with citations, whereas the administrator in D.K. could have supported its determination with citations to the beneficiary's medical records. Id. D.K. was therefore inapposite. Id.

J.J.H. v. Unum Life Ins. Co. of Am., No. 23-cv-02288-CNS-JPO, 2025 U.S. Dist. LEXIS 130439 (D. Colo. July 9, 2025), was another case in which the court found D.K. inapt. J.J.H. involved a denied claim for disability benefits. The claimant argued that the defendant did not comply with D.K. because it failed to engage in a meaningful dialogue. The court was not persuaded. It found that the defendant provided the reasons for its denial in reasonably clear language across four letters to the claimant. Defendant also supported its determination with reviews by four medical professionals who determined that claimant's restrictions and limitations were not supported. One of the defendant's reviewers also spoke with one of claimant's treating physicians and wrote a piece addressing the opinion of claimant's physician. This satisfied ERISA's requirement that the defendant engage in a meaningful dialogue with claimant.

Decisions like E.W. and J.J.H. reveal that D.K. did not declare war on denial letters. Compliance with ERISA's requirement that a claimant be afforded a full and fair review is important, but courts are not interested in using procedural minutiae to invalidate denials, at least as long as it appears the plan and/or administrator made a good-faith effort to engage in a meaningful dialogue with the claimant. When applying an arbitrary-and-capricious standard of review, it remains the case that the administrator's decision need not be the "best one;" it need only fall "somewhere on a continuum of reasonableness—even if on the low end." Kimber v. Thiokol Corp., 196 F.3d 1092, 1098 (10th Cir. 1999) (quoting Vega v. National Life Ins. Serv., Inc., 188 F.3d 287, 297 (5th Cir. 1999)).

Nonetheless, D.K. and similar cases should serve as a cautionary tale to plans and administrators. Consistent with their fiduciary obligations, prudent plans and administrators will review their processes for preparing denial notices to ensure that claimants are being afforded the full and fair review to which they are entitled under ERISA.

PRACTICAL POINTERS FOR DRAFTING DENIAL NOTICES IN THE WAKE OF D.K. AND SIMILAR CASES

Plans and administrators have a fiduciary obligation to provide participants and beneficiaries with a "reasonable opportunity" for a "full and fair review" by drafting denial letters that engage in a "meaningful dialogue" between the plan and the claimant. Not only is this the law, it's also the right way to treat participants and beneficiaries. It's "how civilized people communicate with each other regarding important matters." D.K., 67 F.4th at 1240 (quoting Booton, 110 F.3d at 1463).

Yet there are also practical realities to consider. Large third-party administrators may handle

tens of millions of claims each year. Their ability to handle such a high volume of claims creates economies of scale that result in savings to the plans they administer. In an effort to achieve greater savings that can be passed along to their customers, and to stay competitive in the marketplace, administrators are investing heavily in ways to further automate the claims-adjudication process. Participants and beneficiaries will ultimately benefit from these changes, but there may be a tension between ERISA's demand for a "full and fair review" and the ability of an automated claims process to satisfy that demand, at least for now.

Achieving a balance between these countervailing considerations is not easy. No doubt D.K. and similar cases have not made it any easier. A few lessons can be drawn from them to avoid having denials invalidated based on the content, or lack thereof, of denial notices.

First, avoid relying on form letters if possible. In an ideal world, every denial notice would be bespoke, but this is simply impractical. Claims adjudication processes would become hopelessly bogged down, risking violations of prompt pay statutes. Some reliance on automated or template denial letters is to be expected, and, indeed, is necessary. Prudent plans and administrators would be wise to avoid complete reliance on automated or template denial letters that do not address and refute the claimant's evidence. Instead, the use of partially automated letters or fillable templates is recommended so that medical directors, third-party physicians, and other reviewers can succinctly and thoroughly incorporate their responses to the claimant's evidence into letters without having to draft them from scratch each time. This creates a happy medium between the discrepant demands of efficiency and full-and-fair review.

Second, identify the specific plan provisions at issue and the specific reasons for denial in concise, plain language. If particular guidelines, such as InterQual, are relied on, cite those in the letter and explain why they are not satisfied, or how they are. Conclusory statements ("you are better") or abstract statements made without reference to the plan criteria or applicable guidelines are not sufficient.

Third, engage with contrary evidence. This requires the plan or administrator to do more than acknowledge, cite, or reference contrary evidence. The plan or administrator must discuss the contrary evidence and why it was not sufficient to result in an award of benefits. A great way to do this is to engage in direct discussions with the claimant's medical professionals, when possible, and document those discussions in communications to the claimant. These types of "peer to peer" discussions often cut to the heart of a dispute, result in direct engagement with the claimant's evidence, and, most importantly, evince a good-faith effort to afford the claimant a full and fair review. This is the "core" of the meaningful dialogue requirement. D.K., 67 F.4th at 1241. Plans and administrators cannot turn a blind eye to the claimant's evidence, or even get by with a passing reference to it, following D.K. and similar cases.

Fourth, engage with contrary evidence in the communications with the participant or beneficiary. Do not rely on internal notes to show that the claimant's evidence was weighed and rejected. A "meaningful dialogue" requires a dialogue. Internal notes and similar documents that aren't shared with the claimant do not satisfy the requirement.

Fifth, keep the denial rationale consistent. Courts see shifting denial rationales as a red flag. They invite skepticism and give courts an easy basis to find that a decision was arbitrary and capricious.

Plans and administrators that heed the above recommendations should satisfy ERISA's requirement that participants and beneficiaries be afforded a full and fair review, even if the reviewing court takes a more skeptical approach to review following D.K. and similar cases.

CONCLUSION

The failure to afford participants and beneficiaries a full and fair review can result in judicial invalidation of otherwise meritorious denials of benefits. While the impact of *D.K.* and similar cases has been overhyped by some in the plaintiff's bar, plans and administrators should be mindful of their holdings and the scrutiny of denial letters applied therein, particularly when claims involve residential facility treatment of mental illnesses. By adhering to some simple practices when drafting denial notices, plans and administrators can fulfill their fiduciary obligations and preserve plan assets so that they are available for the participants and beneficiaries that really need them.

“What we’ve got here is failure to communicate.”

COOL HAND LUKE (WARNER BROS. 1967)