

Employers: Your Benefit Claim Denial Letters Must Comply with ERISA

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PRACTICES Employee Benefits and Executive Compensation

A recent case out of the Southern District of New York provides two important reminders for employers that sponsor group health plans – (i) your benefit claim denial letters must comply with all applicable ERISA requirements, and (ii) you should not assume that your third-party administrator (“**TPA**”) will meet this standard.

In *Doe v. Deloitte LLP Group Insurance Plan*, the Plaintiff, a participant in the Deloitte LLP Group Insurance Plan (the “**Plan**”), challenged the denial of health benefits related to an out-of-network residential treatment center for his dependent son. The Plan generally excluded coverage for out-of-network providers; however, it did allow participants to seek a “single case agreement” for a certain out-of-network provider if circumstances justified an exception.

Plaintiff relied on this single case agreement in his initial claim and administrative appeals, arguing that the Plan’s in-network coverage options for the necessary treatment were inadequate. The Plan’s claims administrator, Aetna Life Insurance Company (“**Aetna**”), did not address the single case agreement in any of its denial letters, stating only that the residential treatment center was not covered because it was an out-of-network provider. Consequently, Plaintiff challenged the benefits denial by filing an action under ERISA in federal court.

On summary judgment, the court concluded that Aetna’s denial of benefits was “arbitrary and capricious” under ERISA’s standards because Aetna did not adequately explain the basis for denial. The benefit denial letters failed to address whether a single case agreement for the out-of-network provider at issue would be authorized. Consequently, the Plan administrator violated ERISA by failing to “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.” The court remanded the case back to Aetna for a new review and further explanation of the basis for its decision.

Benefit claim denial notices must meet detailed regulatory requirements. An employer that is the responsible fiduciary under a group health plan is responsible, and potentially liable, for a deficient claim denial communication – even if the communication is issued by a TPA. Employers should thus ensure that all benefit claim denial letters comply with ERISA’s requirements.

The opinion in *Doe v. Deloitte LLP Group Insurance Plan* is available [here](#).