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United States Court of Appeals
Tenth Circuit

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Christopher M. Wolpert
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PUBLISH

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

DAVID P.; L. P.,

Plaintiffs - Appellees,

v.

UNITED HEALTHCARE INSURANCE COMPANY; MORGAN STANLEY CHIEF HUMAN RESOURCES OFFICER; THE MORGAN STANLEY MEDICAL PLAN,

Defendants - Appellants.

No. 21-4129

Appeal from the United States District Court
for the District of Utah
(D.C. No. 2:19-CV-00225-JNP-JCB)

Amanda Shafer Berman (Jennifer S. Romano, Crowell & Moring LLP, Los Angeles, California, and Amy M. Pauli, Crowell & Moring LLP, Washington, D.C., with her on the briefs), Crowell & Moring LLP, Washington, D.C., for Defendants-Appellants.

Brian S. King (Tera J. Peterson with him on the brief), Brian S. King P.C., Salt Lake City, Utah, for Plaintiffs-Appellees.

Before **CARSON**, **BALDOCK**, and **EBEL**, Circuit Judges.

EBEL, Circuit Judge.

In this action under the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ("ERISA"), Plaintiffs David P. and his daughter L.P. sought to recover health care benefits under a medical plan David P. obtained through his employer. The district court awarded Plaintiffs benefits, determining that the manner in which Defendants processed Plaintiffs' claims for coverage violated ERISA. We agree, concluding Defendants' deficient claims processing circumvented the dialogue ERISA mandates between plan participants claiming benefits and the plan administrators processing those benefits claims. We disagree with the district court, however, as to the appropriate remedy for the violations of ERISA's claims-processing requirements at issue here. Rather than outright granting Plaintiffs their claimed benefits, we conclude, instead, that Plaintiffs' claims for benefits should be remanded to Defendants for proper consideration. Having jurisdiction under 28 U.S.C. § 1291, we, therefore, AFFIRM the district court's ruling that Defendants violated ERISA, but we REVERSE the district court's decision to award Plaintiffs benefits and, instead, REMAND this case to the district court with directions to remand Plaintiffs' benefits claims to Defendants.

I. GOVERNING ERISA PRINCIPLES

Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 830 (2003) (quoting Firestone Tire & Rubber v. Bruch, 489 U.S. 101, 113 (1989)). A plan's administrator is a fiduciary who "'owes a special duty of loyalty to the plan beneficiaries.'" D.K. v. United Behavior

Health, 67 F.4th 1224, 1236 (10th Cir. 2023) (quoting Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008)). ERISA promotes the interests of plan participants and beneficiaries and protects contractually defined benefits "in part by regulating the manner in which plans process benefits claims." Black & Decker, 538 U.S. at 830. Relevant here, ERISA does that by specifying minimum requirements for a plan's claims-processing procedure. See Aetna Health Inc. v. Davila, 542 U.S. 200, 220 (2004). Those minimum claims-processing requirements are set forth in 29 U.S.C. § 1133, which prescribes the following two-step process for denying benefits.

A. Initial denial of benefits

First, § 1133(1) requires that "every employee benefit plan . . . 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 Department of Labor ("DOL") fleshed out this statutory requirement through regulations implementing § 1133(1). Those regulations further specify that benefit-denial notices sent to claimants set forth, among other things,

- "[t]he specific reason or reasons for the adverse determination,"
- "the specific plan provisions on which the determination is based," and
- "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary."

29 C.F.R. § 2560.503-1(g)(1)(i), (ii), and (iii). In addition, where, as in this case, the benefits denial is made by a "group health plan" and "is based on a medical necessity

. . . exclusion or limit," the administrator must also provide the claimant with "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances." Id. § 2560.503-1(g)(1)(v)(B).

B. Administrative review of a benefits denial

The second step in the required claim-denial process is found in 29 U.S.C. § 1133(2), which requires that "every employee benefit plan . . . 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." ERISA's implementing regulations further require, among other things, that a plan's administrative review procedures

> - "[p]rovide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits," and
>
> - "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination."

29 C.F.R. § 2560.503-1(h)(2)(ii) and (iv). In addition, where, as here, the plan is a "[g]roup health plan[]," it must, among other things, further

> [p]rovide for a review that does not afford deference to the initial adverse benefits determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Id. § 2560.503-1(h)(3)(ii).

For the claimant, then, the "full and fair" administrative review required by ERISA "means '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 & Tr., 845 F.2d 885, 893–94 (10th Cir. 1988) (quoting Grossmuller v. UAW, Local 813, 715 F.2d 853, 858 n.5 (3rd Cir. 1983)).

C. In sum, ERISA requires meaningful dialogue between a plan participant claiming benefits and the plan administrator considering that benefits claim

29 U.S.C. § 1133 and its implementing regulations thus require

> a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied the reason for the denial must be stated in reasonably clear language[,] if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.

Rasenack ex rel. Tribolet v. AIG Life Ins. Co., 585 F.3d 1311, 1326 (10th Cir. 2009) (quoting Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 635 (10th Cir. 2003)).

> Congress intended these [claim] review procedures "to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned." Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980). Absent such safeguards, mounting costs of administering a plan might discourage employers from establishing such plans. Cf. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) (civil enforcement scheme of 29 U.S.C. § 1132 "represents a careful balancing of the need for prompt and fair claims settlement procedure against the public interest in encouraging the formation of employee benefit plans.").

Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 382 (10th Cir. 1992).[1]

ERISA's

> goals are undermined where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary. Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits.

Spradley, 686 F.3d at 1140 (quoting Glista, 378 F.3d at 129 (1st Cir.)). That is why

> federal courts will consider only "those rationales that were specifically articulated in the administrative record as the basis for denying a claim." "The reason for this rule is apparent[:] we will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation." A plan administrator may not "treat the administrative process as a trial run and offer a post hoc rationale in district court."

Id. at 1140–41 (quoting Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co., 491 F.3d 1180, 1190–92 (10th Cir. 2007), overruled on other grounds by Glenn, 554 U.S. at 116–17, as recognized in Holcomb v. Unum Life Ins. Co., 578 F.3d 1187, 1192–93 (10th Cir. 2009)).

II. THIS CASE

David P. initiated this ERISA action seeking coverage under a group health plan he obtained through his employer, Defendant Morgan Stanley Medical Plan ("Plan"). David P.'s teenage daughter L.P. was a beneficiary under the Plan. The claimed benefits at issue here were for L.P.'s year-long mental health and substance

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[1] See also Spradley v. Owens-Illinois Hourly Emps. Welfare Ben. Plan, 686 F.3d 1135, 1140 (10th Cir. 2012) (citing Glista v. Unum Life Ins. Co., 378 F.3d 113, 129 (1st Cir. 2004), and Powell v. AT & T Commc'ns., Inc., 938 F.2d 823, 826 (7th Cir. 1991)).

abuse treatment that occurred at two residential treatment centers ("RTC"), Summit Achievement and Uinta Academy.

The Plan's administrator, Defendant Morgan Stanley's Chief Human Resources Officer, delegated his discretion to decide benefits claims to designated claims administrators, including Defendant United Healthcare Insurance Company ("United"). United administered the Plan's mental health/substance abuse benefits through its affiliate, United Behavioral Health ("UBH"). The Plan gave UBH "discretionary authority to interpret Plan provisions, set coverage criteria consistent with the Plan, and make decisions regarding specific claims for benefits and appeals of benefit denials." (2 Aplt. App. 25 (citing Admin. Rec. 210).) At issue here, UBH denied coverage for all of L.P.'s stay at Summit and almost all of her stay at Uinta.[2]

A. The Plan

The Plan covered mental health and substance abuse services that are "medically necessary," and defined "medically necessary" as

> [t]hose services . . . that are determined by the health plan administrator to be:
>
> > Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease
> >
> > Not for experimental, investigational or cosmetic purposes
> >
> > Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms

[2] Because it was UBH that denied Plaintiffs' benefits claims at issue here, we refer to Defendants collectively as UBH.

> Within generally accepted standards of medical care in the community
>
> Not solely for the convenience of the employee, the employee's family or the provider

(3 Aplt. App. 215 (2016 Plan); see also 4 Aplt. App. 131 (2017 Plan).)

UBH, exercising its discretion under the Plan, developed guidelines it used to decide whether the Plan covered a claim for mental health/substance abuse treatment. Among other things, these guidelines provided for increasing levels of care across a wide spectrum, ranging from outpatient therapy to programs offering "intensive outpatient," "day treatment," or "partial hospital[ization]," to residential treatment in centers like Summit and Uinta, as well as crisis stabilization, twenty-three-hour observation, and inpatient hospital care. (4 Aplt. App. 141 (2017 Plan).) The RTCs at issue in this case, then, fell in the middle of this level-of-care spectrum of mental health/substance abuse treatment covered by the Plan.

The Guidelines defined an RTC as

> [a] sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.
>
> The course of treatment in a[n] [RTC] is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intense level of care.

(Id. at 149–50.)

Under these level-of-care guidelines, admission to an RTC is warranted when, among other requirements,

- The [Plan] member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors. Examples include the following:

  - Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

  - Psychosocial and environmental problems are likely to threaten the member's safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

(Id. at 150.)

B. L.P.'s treatment

As briefly summarized by the district court, L.P.'s mental health and substance abuse problems began in high school, where L.P. "struggled to connect with peers and became increasingly isolated"; she "reported hearing voices in her head and experienced anxiety attacks serious enough that her parents had to pick her up from school"; "[s]he began to cope by self-harming—burning, cutting, and tattooing her skin"; she "increasingly used drugs and alcohol," and "brought alcohol to school and began driving while intoxicated." (2 Aplt. App. 27.) Her treating psychologist noted that L.P. "had numerous episodes of cutting, driving to endanger, being uncooperative and oppositional at home and in the community and has had

significant opioid drug involvement." (Id. at 27–28.) Fearing L.P. "might be a danger to herself or others" and concluding that "[o]utpatient therapy and psychopharmacological treatment with [L.P.] and her family were insufficient to address her emotional, psychological and physical needs," L.P.'s treating psychologist "on numerous occasions" recommended "hospitalization." (Id. at 28.)

L.P.'s parents admitted her to two residential treatment programs in succession. L.P. spent from November 28, 2016, through February 13, 2017, at Summit Achievement ("Summit"), an RTC located in Maine. (David P. and his family lived in Massachusetts.) Upon being discharged from Summit, L.P. was immediately admitted to Uinta Academy ("Uinta"), an RTC located in Utah, where L.P. remained until at least November 30, 2017.[3] L.P.'s admission to Uinta followed recommendations made by the psychologist and a therapist who treated L.P. at Summit that L.P. needed a longer-term residential treatment program.

C. UBH denies coverage for almost all of L.P.'s treatment at these two RTCs

At the outset of our discussion of UBH's decisions to deny coverage for almost all of L.P.'s stays in these two RTCs, we note two things. First, although 29 U.S.C. § 1133 prescribes a two-part claim-denial process involving an initial denial and an administrative appeal, the Plan at issue here actually provided four levels of claim review—an initial decision and two levels of administrative review conducted

[3] L.P. remained in treatment at Uinta after November 30, 2017, but on that date David P. terminated his coverage under the Plan at issue here. This litigation, then, involves coverage under the Plan only through November 30, 2017.

by UBH, followed by review, at the claimant's request, by an external reviewer independent from UBH. Second, as we previously noted, in reviewing UBH's denial of benefits, we look only to the reasons for the denial that UBH specifically articulated in the administrative record and conveyed to Plaintiffs. See Spradley, 686 F.3d at 1140–41 (citing Flinders, 491 F.3d at 1190–92).

1. Plaintiffs' claim for coverage for L.P.'s stay at Summit

L.P. was admitted to Summit on November 28, 2016, and remained there until February 13, 2017. Her discharge summary indicated that Summit treated L.P. for anxiety, depression, ADHD, substance use, borderline personality disorder, and executive function deficit. UBH denied coverage for all of L.P.'s stay at Summit.

In reviewing that denial of coverage, we note, as an initial matter, that UBH suggests, at places in the administrative record and in its opening brief filed with this court, that Summit does not qualify as an RTC under the terms of the Plan.[4] But, because UBH never denied coverage for that reason, we do not consider that question of whether Summit should be deemed an RTC. See Spradley, 686 F.3d at 1140–41.

a. Initial denial

UBH initially denied coverage because David P. had not sought preauthorization from UBH for L.P.'s stay at Summit.

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[4] For example, UBH's internal notes indicate that before L.P. was admitted to Summit, David P. inquired of UBH whether a "Wilderness Program" would be covered under the Plan. (8 Aplt. App. 161.) According to these internal notes, UBH replied no, explaining to David P. the differences between residential treatment programs and wilderness programs. In its opening brief, UBH suggests that Summit was only a wilderness program and, thus, did not qualify as an RTC.

b. First-level administrative appeal denied

David P. administratively appealed that initial denial, asserting that the Plan did not require preauthorization. In light of that, David P. requested that UBH retrospectively review the medical necessity of L.P.'s treatment at Summit and, in support of that request, he attached some of L.P.'s medical records for UBH's review.

UBH denied this first-level administrative appeal. In doing so, UBH abandoned its original assertion that preauthorization was needed. Instead, UBH denied coverage for different reasons. Citing the level-of-care guidelines for mental health/substance abuse treatment, UBH's reviewer (Dr. Iqbal), stated:

> There is no clinical information received that indicates that your daughter required 24 hour monitoring to treat acute mental health symptoms. She did not want to hurt herself. She did not want to hurt others. It seems that her mood and anxiety symptoms could have been treated in a less intensive setting.

(4 Aplt. App. 156–57.)

c. Second-level administrative appeal denied

David P. appealed UBH's first-level administrative appeal denial, this time submitting a twenty-three-page letter which provided a chronological history of L.P.'s conditions along with over 300 pages of supporting documentation. In response to UBH's statement that "[t]here is no clinical information . . . that indicates that your daughter required" this level of treatment (id. at 156–57), David P. set forth "the many attempts we made to treat [L.P.'s] conditions at a lower level of care" (id. at 185), and noted that, because less intensive treatments had not helped L.P., her

treating psychologist had recommended a residential treatment program over less intensive treatment options. David P. also pointed out that several of L.P.'s care givers at Summit, in turn, also recommended still further long-term residential treatment.

In response to UBH's statement that L.P. "did not want to hurt herself" (id. at 157), David P. pointed out that L.P. had cut herself both before and after being admitted to Summit, and that she had reported suicidal ideation several times while at Summit.[5] David P. also informed UBH that it had overlooked L.P.'s substance use disorder as an independent ground for coverage.

Again applying the level-of-care guidelines, UBH (Dr. Collopy) denied David P.'s second administrative appeal, too, stating that, "[a]fter reviewing the appeal documents, there was no clinical information provided to support the medical necessity for treatment in a psychiatric residential setting or to document the daily provision of treatment services." (Id. at 172.)

In restating that "there was no clinical information provided to support the medical necessity for treatment in a psychiatric residential setting" (id.), UBH did not mention either the recommendation of L.P.'s treating care givers that she needed treatment in a residential care facility or L.P.'s reported cutting and suicidal ideation

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[5] UBH's belief that L.P. did not want to hurt herself or others would seem, in any event, to support treatment in an RTC because the level-of-care guidelines indicate that treatment in an RTC is warranted when, among other things, the claimant "is not in imminent or current risk of harm to self, others, and/or property." (4 Aplt. App. 150 (emphasis added).)

while at Summit. Nor did UBH address L.P.'s treatment at Summit for substance abuse.

Additionally, although ERISA's regulations require an administrator to describe any additional information it needs, see 29 C.F.R. § 2560.503-1(g)(1)(iii), this denial was the first time UBH mentioned that there was insufficient documentation of L.P.'s "daily . . . treatment services" at Summit. (4 Aplt. App. 172.) Because this was UBH's final level of administrative review, David P. had no opportunity to obtain any such information and provide it to UBH.

d. External review

David P. next requested an external review of UBH's denial of benefits. External reviewer AllMed Healthcare Management affirmed UBH's decision to deny Plaintiffs' claim for coverage.

2. Plaintiffs' claim for coverage for L.P.'s stay at Uinta

Immediately upon being discharged from Summit, L.P. was admitted to Uinta Academy. UBH authorized coverage for the first eight days of L.P.'s stay at Uinta—from February 14, 2017, through February 21, 2017—but, as explained next, UBH denied coverage for the rest of her stay there through November 30, 2017.

a. Initial denial

UBH (Dr. Gallegos) initially denied further coverage beyond L.P.'s first eight days at Uinta. This denial, dated March 2, 2017, occurred just over two weeks after L.P. was first admitted to Uinta. This denial referenced the level-of-care residential treatment guidelines and stated:

> After talking with your child's provider[] designee, it is noted that your child has made progress and that her condition no longer meets Guidelines for further coverage of treatment in this setting. Your child's mood is more stable. She is participating in her treatment. She is not having any serious mental health issues. She no longer needs the 24/7 care of a Residential setting. Your child could continue care in the Mental Health Partial Hospitalization Program setting.[6]

(11 Aplt. App. 176 (footnote added).)[7]

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[6] Under UBH's level-of-care guidelines, partial hospitalization is a step down in intensity from an RTC. A partial hospitalization program is

> [a] structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided [Plan] members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. While a Partial Hospital Program generally maintains at least 20 hours of service per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

(4 Aplt. App. 148.) Similar to an RTC, the purpose of a partial hospitalization program

> is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.
>
> The course of treatment in a Partial Hospital Program is focused on addressing factors that precipitated admission (e.g., changes in the member's sign and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

(Id.)

[7] By noting that L.P.'s "condition no longer meets Guidelines" for treatment in an RTC (11 Aplt. App. 176 (emphasis added)), this denial suggested that her condition had initially met those requirements when she left Summit and entered Uinta, notwithstanding UBH's denial of coverage for L.P.'s stay at Summit. On appeal, however, UBH asserts, instead, that it covered the first eight days of L.P.'s stay at

In its appellate brief, UBH now suggests to us that, in light of the minimal treatment Uinta was providing L.P. and in particular because she was not regularly seeing a psychiatrist, Uinta did not qualify as an RTC under UBH's guidelines. We do not consider that assertion, however, because UBH did not rely on that reasoning to deny coverage. See Spradley, 686 F.3d at 1140–41.

b. First-level administrative appeal denied

David P. administratively appealed this initial denial. In support of his appeal, David P. included a twenty-eight-page letter and supporting documentation for UBH's review. In light of UBH's coverage of L.P.'s first week at Uinta, David P. wondered in his letter how, "in one short week, [L.P.] had met her treatment goals and was ready for discharge"? (11 Aplt. App. 252.[8]) David P. again chronicled for UBH "the many [unsuccessful] attempts we made to treat her conditions at a lower level of care" (id. at 254), noted that L.P.'s treating care givers recommended further residential treatment, and again pointed out that L.P.'s substance abuse disorder

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Uinta only in order to have time to gather information to address better Plaintiffs' request for coverage for L.P.'s treatment at Uinta. Although there is an internal UBH note that indicates that this was the reason for covering the first eight days at Uinta, it does not appear that UBH ever conveyed that reasoning to David P.

[8] On appeal, in arguing to us in support of its denial of coverage for L.P.'s stay at Uinta after February 21, 2017, UBH now cites progress notes from several months later, in June and August 2017. In addition to the problem that UBH did not convey to Plaintiffs that these later progress notes supported denying their claim for coverage, as a practical matter these later notes do not support UBH's initial denial of coverage after February 21, 2017.

would provide an additional ground for coverage independent of her mental health treatment.

Seven months after her admission to Uinta, UBH (Dr. Satten) denied David P.'s level-one administrative appeal for coverage from February 22, 2017, forward, for reasons almost identical to the initial denial:

> Your child was admitted for treatment of impaired behaviors and poor coping skills. After reviewing the available clinical information, it was noted your child had made progress and that her condition no longer met Guidelines for further coverage of treatment in this setting. Your child's mood was more stable. She was participating in her treatment. She was not having any serious mental health issues. She no longer needs the 24/7 care of a residential setting. Your child could continue care in a Mental Health Partial Hospitalization Program setting.

(8 Aplt. App. 226–27.)

c. Level-two administrative appeal denied

David P. sought a second-level administrative appeal. In April 2018, UBH (Dr. Jones) denied this appeal, stating to L.P.:

> You[] were admitted for treatment of problems with your mood, behavior, and addiction. After reviewing the available information, it is noted that you had made progress and that your condition no longer met Guidelines for further coverage of treatment in this setting. You were doing better. You were stable from a medical and mental health standpoint. You were not thinking about hurting yourself or others. You were thinking clearly. You were motivated. You were participating in treatment and using the skills learned. You were able to take care of your needs. You were able to go on leaves of absence. You had family support. You did not require 24 hour nursing care. You could have continued care in the Mental Health Partial Hospitalization Program setting.

(10 Aplt. App. 250–51.)

This was the first time that UBH acknowledged L.P.'s treatment for substance abuse, although UBH still did not expressly address why coverage was not warranted for that treatment. Further, it is not clear why UBH mentioned that L.P. did not require nursing care, because there was never a suggestion in the record that she might require that type of care, which is a higher level of care than that provided by an RTC.

d. External review

David P. next requested an external review. External reviewer Advanced Medical Reviews, Inc., affirmed UBH's denial of coverage.

D. The district court reverses UBH's denial of coverage and awards Plaintiffs benefits

Plaintiffs initiated this ERISA action under 29 U.S.C. § 1132(a)(1)(B) seeking to recover benefits for the entirety of L.P.'s stays at both Summit and Uinta.[9] Both parties moved for summary judgment; the district court granted Plaintiffs' motion and denied UBH's motion. As relief, the district court awarded benefits to Plaintiffs. Defendants challenge those decisions in this appeal.[10]

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[9] Plaintiffs also asserted an ERISA claim alleging Defendants failed to provide David P. with plan documents; the district court dismissed that claim under Fed. R. Civ. P. 12(b)(6). In addition, Plaintiffs alleged a claim under the Mental Health Parity and Addiction Equity Act, see 29 U.S.C. § 1185a, which the district court deemed moot after the court granted Plaintiffs their claimed benefits. Plaintiffs do not challenge either of those rulings on appeal.

[10] We reject Plaintiffs' suggestion that Defendants failed to establish this court's appellate jurisdiction. Defendants perfected this court's jurisdiction by filing an initial notice of appeal after the district court's summary judgment decision awarding Plaintiffs benefits and then filing an amended notice of appeal after the district court

III. STANDARD OF REVIEW

We review the district court's summary judgment decision de novo, applying the same standard that the district court applied. See LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan, 605 F.3d 789, 795 (10th Cir. 2010). Here, because the Plan gave UBH discretion to interpret the Plan, to develop the criteria by which benefits determinations would be made, and to make those benefits determination, the district court ultimately reviewed UBH's decision to deny Plaintiffs' claims for benefits for an abuse of discretion. See Firestone, 489 U.S. at 111, 115. In this appeal, therefore, we consider de novo whether UBH abused its discretion in denying Plaintiffs benefits. See Graham v. Hartford Life & Acc. Ins. Co., 589 F.3d 1345, 1357 (10th Cir. 2009).

In considering whether UBH abused its discretion, we ask whether its denial of benefits was arbitrary and capricious.[11] See id. We thus ask whether UBH's "interpretation of the plan was reasonable and made in good faith," LaAsmar, 605

later entered its final judgment. See Fed. R. App. P. 4(a)(2) ("A notice of appeal filed after the court announces a decision or order--but before the entry of the judgment or order--is treated as filed on the date of and after the entry."); see also Underwood v. Bank of Am. Corp., 996 F.3d 1038, 1049 (10th Cir. 2021).

[11] Notwithstanding the fact that the Plan gave UBH discretion to interpret the Plan and determine benefits, the district court noted that here, because "UBH's denial of benefits suffered from serious procedural irregularities," de novo review was warranted. (2 Aplt. App. 42.) See LaAsmar, 605 F.3d at 796–800. Nevertheless, the district court ultimately reviewed UBH's decisions to deny benefits for an abuse of discretion, stating that "the court need not provide an extensive de novo review analysis here because UBH's adverse benefits determination fails even an arbitrary and capricious standard of review." (2 Aplt. App. 42.) We apply that same arbitrary-and-capricious standard here in reviewing UBH's benefits denials.

F.3d at 796 (quoting Kellogg v. Metro. Life Ins. Co., 549 F.3d 818, 825–26 (10th Cir. 2008)), and whether UBH's benefits determination "is predicated on a reasoned basis," Ellis v. Liberty Life Assurance Co., 958 F.3d 1271, 1290 (10th Cir. 2020) (quoting Adamson v. Unum Life Ins. Co., 455 F.3d 1209, 1212 (10th Cir. 2006)).

"Certain indicia of an arbitrary and capricious denial of benefits include 'lack of substantial evidence [and] mistake of law.'" Graham, 589 F.3d at 1357–58 (quoting Caldwell v. Life Ins. Co. of N. Am., 287 F.3d 1276, 1282 (10th Cir. 2002)). "We define substantial evidence as 'such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the decision-maker. Substantial evidence requires more than a scintilla but less than a preponderance.'" Id. at 1358 (quoting Sandoval, 967 F.2d at 382). "'In determining whether the evidence in support of the administrator's decision is substantial, we must take into account whatever in the record fairly detracts from its weight.'" Id. (quoting Caldwell, 287 F.3d at 1282).

> "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician," Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003), but a benefits decision can be reasonable even when the insurer receives evidence contrary to the evidence it relies on, see Holcomb v. Unum Life Ins. Co. of Am., 578 F.3d 1187, 1193–94 (10th Cir. 2009). "[C]ourts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." Black & Decker, 538 U.S. at 834.

Ellis, 958 F.3d at 1290.

> Where, as here, the parties in an ERISA case both moved for summary judgment and stipulated that no trial is necessary, "summary judgment is merely a vehicle for deciding the case; the factual determination of

> eligibility for benefits is decided solely on the administrative record, and the non-moving party is not entitled to the usual inferences in its favor."

LaAsmar, 605 F.3d at 796 (quoting Bard v. Boston Shipping Ass'n, 471 F.3d 229, 235 (1st Cir. 2006)).

IV. DISCUSSION

As explained next, we agree with the district court that UBH abused its discretion because the manner in which it denied Plaintiffs' claims for benefits violated ERISA's claims-processing requirements. In reaching that conclusion, we further determine that UBH cannot rely on the reasoning in its internal notes, which were never conveyed to Plaintiffs. Nor do the external reviews at issue here correct the deficiencies in UBH's claims processing. Finally, we explain why the district court should have remedied Defendants' ERISA claims-processing violations by remanding Plaintiffs' benefits claims to UBH for its proper consideration, instead of outright awarding Plaintiffs benefits.

A. UBH's deficient claims processing warranted reversal of its decisions to deny Plaintiffs' claims for benefits

1. The district court's specific concerns with UBH's claims processing

As previously explained, there were procedural irregularities in UBH's claim denials. For example, some of UBH's denials were seemingly inconsistent. For one, UBH denied coverage for L.P.'s stay at Summit, but then covered her first week at Uinta, which immediately followed her release from Summit. Furthermore, some of the denials also seemingly contradicted UBH's own guidelines for when coverage was warranted. For instance, UBH denied coverage at Summit because L.P. did not

want to hurt herself or others, but according to UBH's guidelines, treatment in an RTC can be warranted when the insured is not in imminent or current risk of harm to self or others.

In reversing UBH's benefits denials, however, the district court focused on several specific concerns that the court had with UBH's processing of Plaintiffs' claims seeking benefits for L.P.'s treatment at both Summit and Uinta. We agree with the district court that these claims-processing concerns, in particular, deprived Plaintiffs of the meaningful dialogue that ERISA mandates between benefit claimants and the plan administrators deciding those benefits claims. UBH's failure to provide Plaintiffs with this required dialogue warranted reversing UBH's benefits denials.

a. UBH failed to address whether L.P.'s treatment for substance abuse provided an independent ground for coverage

UBH denied coverage for L.P.'s mental health treatment at Summit and Uinta. But UBH never addressed whether her treatment for substance abuse provided an independent ground for coverage of her stays at either Summit or Uinta. An administrator's claim denial is arbitrary and capricious when the administrator fails to address an independent ground for paying benefits that was "presented in the record and specifically raised in [the claimant's] administrative appeal." Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 806 (10th Cir. 2004). On that basis, the district court correctly held that UBH abused its discretion when it failed to consider whether

L.P.'s treatment for substance abuse warranted Plan coverage for her stays at either RTC.[12]

Contrary to UBH's assertion on appeal, it was clear from the record before UBH that Summit and Uinta were each treating L.P. for substance abuse, in addition to providing mental health treatment. Moreover, David P. consistently stated in his administrative appeals filed with UBH that L.P.'s substance abuse treatment could provide a basis for coverage under the Plan, independent of her mental health treatment. Yet UBH never addressed that possibility. Only a single UBH reviewer acknowledged "addiction" among the conditions for which L.P. was receiving treatment (10 Aplt. App. 250), but even then that reviewer did not separately state why L.P.'s substance abuse treatment did not warrant coverage.

In its appellate brief filed with us, UBH asserts several reasons why coverage for L.P.'s substance abuse treatment was not warranted under the Plan, including that 1) L.P. stopped using drugs prior to entering Summit, and 2) she was being treated at both RTCs primarily for ADHD, not substance abuse. But UBH's reviewers never asserted any of these reasons for denying coverage in their correspondence with Plaintiffs. We, therefore, do not consider these newly asserted reasons here. See

[12] Gaither involved a claim for disability, rather than health care, benefits. See 394 F.3d at 794. Nonetheless, 29 C.F.R. § 2560.503-1(h)(2) requires that plan administrators provide claimants seeking either kind of benefit—disability or health care—"full and fair" administrative review of the initial denial of a claim. That regulation stems from ERISA's general statutory requirement that "every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2).

Spradley, 686 F.3d at 1140–41. UBH's failure to address L.P.'s substance abuse treatment as an independent ground for coverage thus supports reversing UBH's denial of Plaintiffs' benefits claims.

b. UBH failed to engage with the opinions of L.P.'s treating care givers that she required treatment in an RTC

We also agree with the second reason the district court identified to reverse UBH's denial of benefits: that UBH failed to engage with the recommendations made by L.P.'s treating care givers that she required treatment in a residential care setting.[13] While "an administrator is not required to defer to the opinions of a treating physician," "a reviewer may not arbitrarily refuse to credit opinions if they constitute reliable evidence from the claimant." D.K., 67 F.4th at 1237 (citing Black & Decker, 538 U.S. at 831, 834). "Medical opinions are regularly proffered as proof of a claim, and we have held reviewers 'cannot shut their eyes to readily available information . . . [that may] confirm the beneficiary's theory of entitlement.'" Id. (quoting Gaither, 394 F.3d at 807). UBH never acknowledged the opinions of L.P.'s

[13] As one example of this, in denying David P.'s first-level administrative appeal of the denial of coverage for L.P.'s stay at Summit, UBH stated: "There is no clinical information received that indicates that your daughter required 24 hour monitoring to treat acute mental health symptoms. . . . It seems that her mood and anxiety symptoms could be treated in a less intensive environment." (4 Aplt. App. 156–57.) David P. responded to UBH in his second-level appeal by pointing out that several of L.P.'s treating care givers opined that she required treatment in an RTC rather than at a lower-intensity care level. Yet, in denying David P.'s second-level appeal, UBH never acknowledged the recommendations of L.P.'s treating care givers but instead simply repeated, inaccurately, that "there was no clinical information provided to support the medical necessity for treatment in a psychiatric residential setting." (Id. at 172.)

treating care givers that David P. relied upon in his administrative appeal. By simply ignoring the treating care givers opinions, after David P. specifically pointed them out, UBH deprived Plaintiffs of the dialogue ERISA requires between plan administrators and benefits claimants, which is necessary for the statutorily-required "full and fair" administrative review, 29 U.S.C. § 1133(2).

When faced with a similar situation in D.K., this court held that the administrator abused its discretion when it denied benefits without "engag[ing] with and address[ing]" the opinions of three treating health care providers who opined that the claimant needed additional time at an RTC. 67 F.4th at 1237. In that case, we stated: "By not providing an explanation for rejecting or not following these opinions, that is, not 'engaging' with these opinions, United effectively 'shut its eyes' to readily available medical information." Id. "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. That same reasoning applies here and warrants reversing UBH's denial of benefits.

For the first time before us in its reply brief, UBH points to the differences in ERISA's implementing regulations that apply to the initial denial of claims for health care benefits and regulations that apply, instead, to the initial denial of disability claims. UBH suggests that the difference in these regulations supports its contention that it need not explain to Plaintiffs why it disregarded the opinions of L.P.'s treating

care givers. That argument is waived[14] and, in any event, it is unpersuasive on its merits.

Currently, the regulations that apply to the initial denial of disability claims require an administrator to explain why it disagrees with the views of a treating health care provider (as well as the advice of the administrator's medical and vocations experts and the Social Security Administration's disability determinations). See 29 C.F.R. § 2560.503-1(g)(1)(vii)(A)(i), (ii), and (iii). On the other hand, the regulations that apply here, to the initial denial of a claim for health care benefits, do not require such an explanation but instead mandate that when a denial is "based on a medical necessity" exclusion, the administrator must provide "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances." Id. § 2560.503-1(g)(1)(v)(B). In any event, ERISA and its implementing regulations still require a full and fair administrative review for the denial of either disability or health care benefits. 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(1), (2).

"[T]he textual difference in the ERISA disability and ERISA medical regulations" addressing initial denials of claims do not "absolve[] [UBH] from its duty to engage in meaningful dialogue that includes a full and fair review of the insured's claim." D.K., 67 F.4th at 1238; see also id. at 1238–39. Here, that means

[14] See United States v. Salti, 59 F.4th 1050, 1059 (10th Cir. 2023) (stating that argument raised for the first time on appeal in a reply brief is waived).

UBH was not absolved from engaging with the opinions of L.P.'s treating care givers that would provide evidence to support her claim for benefits.

This conclusion does not create any blanket requirement that a health plan administrator considering a claim for health care benefits must seek out all treating care givers' opinions found in a claimant's medical records and explain whether or not the plan administrator agrees with each of those opinions and why. Instead, in the case before us, UBH indicated that there was no clinical information indicating that L.P. needed treatment in an RTC. David P. responded by pointing out opinions from several of L.P.'s care givers that she did require treatment at the RTC level. UBH, nevertheless, never addressed those opinions at all but instead inaccurately continued to assert that there no information indicating L.P. required residential care. Plan administrators "'cannot shut their eyes to readily available information . . . [that may] confirm the beneficiary's theory of entitlement.'" Id. at 1237 (quoting Gaither, 394 F.3d at 807).[15] We, therefore, agree with the district court that, under these facts, reversal of UBH's decisions to deny benefits was warranted because UBH failed to engage with the opinions of L.P.'s treating care givers that she required treatment in an RTC.

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[15] UBH relies on an unpublished decision, Mary D. v. Anthem Blue Cross Blue Shield, 778 F. App'x 580 (10th Cir. 2019) (unpublished), to support UBH's assertion that it was not required to explain why it disagreed with L.P.'s treating care givers' opinions that she required treatment in an RTC. This reliance is misplaced in light of this court's more recent published D.K. decision.

c. UBH failed to address "medical necessity" adequately and failed to explain its judgment in denying David P.'s claims on that basis

The district court's final concern about UBH's decisions to deny Plaintiffs' claims for coverage is related to and builds on the district court's first two concerns. As previously explained, a plan administrator, in initially denying a claim for benefits, must convey to the claimant "[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). In addition, because UBH denied coverage after concluding that L.P.'s treatment at an RTC was not "medically necessary," ERISA's implementing regulations further required UBH to provide Plaintiffs with "an explanation of the scientific or clinical judgment for th[at] determination, applying the terms of the plan to the claimant's medical circumstances." Id. § 2560.503-1(g)(1)(v)(B). Such an explanation "may not be conclusory and any health conclusions must be backed up with reasoning and citations to the record" before the administrator. D.K., 67 F.4th at 1242.

UBH's denial letters to Plaintiffs did not meet these minimal requirements for explaining why it deemed L.P.'s treatment in an RTC not to be medically necessary. None of UBH's denial letters cited to any of L.P.'s records. Nor were many of the statements UBH included in the denial letters "backed up with reasoning," id. For example, returning again to the first-level denial of the Summit claim, it stated: "There is no clinical information received that indicates that your daughter required 24 hour monitoring to treat acute mental health symptoms." (4 Aplt. App. 156–57.)

After David P. responded by submitting several hundred pages of L.P.'s records, including opinions of several treating caregivers that L.P. needed residential treatment, UBH simply stated again: "After reviewing the appeal documents, there was no clinical information provided to support the medical necessity for treatment in a psychiatric residential setting." (Id. at 172.) That appears to be inaccurate and certainly not supported by any stated reasoning.

As another example, the first-level Summit denial also stated that L.P. "did not want to hurt herself" (id. at 157), yet there were indications in her records that L.P. had continued to cut herself at Summit; there was also reported suicidal ideation at least once. That denial letter, then, was also inaccurate and included no reasoning.

Moreover, many of the statements in the letters denying coverage for L.P.'s treatment at both Summit and Uinta were conclusory and failed to refer to any of L.P.'s treatment records. For instance, the first-level Summit denial letter stated: "It seems that [L.P.'s] mood and anxiety symptoms could have been treated in a less intensive setting." (Id.) Later, in initially denying coverage for L.P.'s stay at Uinta beyond her first week, UHB simply stated, without elaboration, that L.P. "has made progress" and her "mood is more stable," again without citation to L.P.'s records. (11 Aplt. App. 176.) The Uinta first-level appeal denial just parroted those same conclusory statements. In the Uinta second-level denial, UBH similarly noted, vaguely, that L.P. was "doing better" and has "made progress" and she was "stable" and "motivated," again without referencing any medical records. (10 Aplt. App. 250–51.) In all three Uinta denials, UBH noted that L.P. "no longer met Guidelines

for further coverage of treatment in this setting," without further explanation. (Id. (emphasis added).) UBH's denial letters, then, failed to explain, in language Plaintiffs could understand, see 29 U.S.C. § 1133(1), exactly why UBH deemed L.P.'s treatment in an RTC to be medically unnecessary. Those denial decisions, then, were not "backed up with reasoning and citations to the record." D.K., 67 F.4th at 1242.

2. UBH's internal notes cannot save UBH's deficient claims-processing

UBH argues that, if a reviewing court considered its internal notes, it would be clear that UBH had adequate and proper reasons to deny Plaintiffs' claimed benefits. We agree with the district court, however, that, in light of the dialogue ERISA requires between the plan administrator and a claimant, a court reviewing an administrator's benefits decisions cannot consider reasons the administrator included in its internal notes when the administrator never conveyed those reasons to the claimant. This court recently held as much in D.K., 67 F.4th at 1242–43. This conclusion flows from this court's earlier decisions indicating that the purposes of ERISA's claims-processing requirements—"'to minimize the number of frivolous lawsuits; promote consistent treatment of claims; provide a nonadversarial dispute resolution process; and decrease the cost and time of claims settlement'"—

> "are undermined where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary. Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits."

Spradley, 686 F.3d at 1140 (quoting Glista, 378 F.3d at 129 (1st Cir.)).[16]

3. The external reviews did not preclude reversing UBH's benefits denials

UBH next argues that the district court erred in reversing UBH's claim denials without considering "the external reviewers' determination that residential care was not medically necessary." (Aplt. Br. 36.) In the district court, UBH argued that its benefits denials should be upheld because they were supported by substantial evidence. In support of that argument, UBH asserted that part of that substantial evidence included the fact that the independent external reviewers reached the same conclusion as UBH, that Plaintiffs' claims for benefits should be denied. In making that assertion, UBH cited cases where a reviewing court relied on external independent reviewers' decisions to deny benefits in order to add further support to the court's own decision to uphold a plan administrator's denial of benefits. UBH reasserts that argument on appeal.

That argument, however, is unavailing and UBH's cited case law is inapposite here, where the district court reversed UBH's benefits denials. The district court reversed, not because there was insufficient evidence to support UBH's decision to

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[16] We need not decide whether UBH's internal notes, had they been conveyed to Plaintiffs in a timely fashion during the interactive process, might have complied with ERISA's claims-processing requirements. But we note that, inexplicably, many of UBH's internal notes were more thorough than the cryptic, vague and unreasoned denial letters UBH sent Plaintiffs. In light of these internal notes, our holding here that UBH must provide Plaintiffs with a more thorough and detailed explanation for its decision to deny coverage would not require UBH to expend significantly more time and resources than it actually has already expended in considering Plaintiffs' claims.

deny benefits, but because UBH abused its discretion by inadequately processing Plaintiffs' claims. As for the external reviewers' decisions, the district court went on to hold that they cannot cure UBH's deficient claims processing. On appeal, UBH does not cite to any authority to the contrary. Nor does UBH argue that the external reviews in this case, by themselves, cured the deficiencies in UBH's deficient claims-processing.

UBH argues, instead, that the external reviews, together with UBH's own review and its internal notes, adequately addressed L.P.'s treatment for substance abuse, adequately engaged with the treating care givers' opinions that treatment in an RTC was necessary, and adequately addressed whether RTC-level treatment was medically necessary. But UBH's argument fails in light of the deficiencies in its claims processing, which we have already identified. The external reviews here, then, do not preclude reversing UBH's denial of benefits.

4. Conclusion: UBH abused its discretion in denying Plaintiffs' benefits claims by failing to comply with ERISA's claims-processing requirements

For the foregoing reasons, we conclude that UBH abused its discretion in denying Plaintiffs' benefits claims because UBH failed to comply with either the letter or the spirit of ERISA's claims-processing requirements. UBH's ERISA violations deprived Plaintiffs of the meaningful dialogue ERISA requires between claimants and the plan administrator deciding their benefits claims. UBH's litigation position suggests it believed, wrongly, that so long as it could later point out to a court substantive reasons to deny Plaintiffs' benefits claims that could be found in the

administrative record, like its internal notes, UBH adequately met the fiduciary obligation it owed Plaintiffs even though UBH never communicated those reasons to Plaintiffs. This belief is in error. The purpose of ERISA's claims-processing requirements is to provide benefits claimants with meaningful dialogue with the administrator in order to prevent frivolous litigation, among other things. If UBH thought Summit did not qualify as an RTC, it could have explained that to Plaintiffs. If UBH disagreed with the treatment recommendations made by L.P.'s treating health care providers, it could have said so and explained why. UBH, instead, abused its discretion by denying Plaintiffs the meaningful dialogue ERISA mandates.

B. The proper remedy for UBH's deficient claims processing is to remand Plaintiffs' claims to UBH for its proper consideration

"Having concluded that [UBH's] decision was arbitrary, 'we may either remand the case to the plan administrator for a renewed evaluation of the claimant's case or we may order an award of benefits.'" Weber v. GE Grp. Life Assurance Co., 541 F.3d 1002, 1015 (10th Cir. 2008) (quoting Flinders, 491 F.3d at 1194). "Which of these two remedies is proper in a given case, however, depends upon the specific flaws in the plan administrator's decision." Flinders, 491 F.3d at 1194 (quoting DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161, 1175 (10th Cir. 2006)). Generally, "[r]emand is appropriate if 'the administrator failed to make adequate factual findings or failed to adequately explain the grounds for the decision.'" Carlile v. Reliance Standard Life Ins. Co., 988 F.3d 1217, 1229 (10th Cir. 2021) (quoting Weber, 541 F.3d at 1015). "But 'if the evidence in the record clearly shows that the claimant is entitled to benefits, an order

awarding such benefits is appropriate.'" Id. (quoting Weber, 541 F.3d at 1015); see also Spradley, 686 F.3d at 1142 (noting generally remand is more appropriate where plan administrator failed to make adequate factual findings or failed to explain adequately the grounds for its decision to deny benefits, but not if the administrator instead gave reasons that were incorrect).

Here, in denying Plaintiffs benefits, UBH failed to consider all of the evidence before it, failed to explain adequately why it denied Plaintiffs' claims, and failed to engage adequately with Plaintiffs. Therefore, the most appropriate remedy is to remand Plaintiffs' claims to UBH for its further, and proper, consideration. See Carlile, 988 F.3d at 1229. Our determination that a remand is the most appropriate remedy in this case is bolstered by the fact that here we cannot say that the "record clearly shows" Plaintiffs are entitled to benefits, nor can we say that Plaintiffs are clearly not entitled to the claimed benefits. Id. (quoting Weber, 541 F.3d at 1015); see DeGrado, 451 F.3d at 1176 (remand is appropriate remedy where the administrator's flaw was in failing to make adequate factual findings and "we cannot say that there is no evidence in the record to support [the administrator's] decision [to increase benefits], or that the evidence so clearly points the other way as to make a remand unnecessary").[17]

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[17] The district court reached a contrary conclusion after applying the wrong legal standard. When the district court addressed the question of remedies, it applied both a de novo and abuse-of-discretion standard of review. In reviewing de novo, the district court indicated that the relevant remedy question was "whether [Plaintiffs'] claim for benefits is supported by a preponderance of the evidence based on the district court's independent review." (2 Aplt. App. 57 (quoting Niles v. Am. Airlines, Inc., 269 F. App'x 827, 832 (10th Cir. 2008) (unpublished)). Finding that

Our remand, however, does not "provide the plan administrator the opportunity to reevaluate a claim based on a rationale not raised in the administrative record," Carlile, 988 F.3d at 1229 (citing Spradley, 686 F.3d at 1142), and not previously conveyed to Plaintiffs.

Lastly, in addition to awarding Plaintiffs benefits, the district court also awarded Plaintiffs' attorney's fees. Because our conclusion that the appropriate remedy here is a remand of Plaintiffs' benefits claims to Defendants, and because that remand differs "significantly" from the district court's remedy of awarding Plaintiffs benefits, we also vacate the district court's award of attorney's fees to Plaintiffs. Cardoza v. United of Omaha Life Ins. Co., 708 F.3d 1196, 1208 (10th Cir.

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the evidence in this case "easily" met "the preponderance of the evidence standard" (id. at 57–59), the district court awarded Plaintiffs benefits.

But the district court in Niles was reviewing de novo the administrator's decision to deny disability benefits. See 269 F. App'x at 832. In considering whether to reverse the denial of benefits, therefore, according to Niles, the relevant question was whether "plaintiff's claim for benefits is supported by a preponderance of the evidence based on the district court's independent review. Id. at 833.

Here, on the other hand, the question is whether, having already determined that UBH abused its discretion in denying Plaintiffs benefits, a remand or an outright award of benefits is the appropriate remedy. In such a case, this court will generally remand for the administrator's reconsideration of the benefits claim unless "the record clearly shows that the claimant is entitled to benefits." Carlile, 988 F.3d at 1229 (quoting Weber, 541 F.3d at 1015) (emphasis added). That is a different, and stricter, standard than Niles was applying. Applying Carlile's clear showing standard to the administrative record before us, we conclude it contains both evidence supporting Plaintiffs' claims for benefits and evidence supporting the denial of benefits. We, therefore, "cannot say that there is no evidence in the record to support [the administrator's] decision, or that the evidence so clearly points the other way as to make a remand unnecessary." DeGrado, 451 F.3d at 1176. A remand to UBH is, therefore, appropriate.

2013). We remand the fee issue for the district court's reconsideration after UBH properly reconsiders Plaintiffs' benefits claims. Id. at 1207–08; see Graham, 501 F.3d at 1154, 1162 (holding issue of attorney's fees was not ripe before plan administrator, on remand, determined whether Plaintiff was entitled to benefits). One way the district court might choose to effectuate its reconsideration of the attorney's fee issue would be to retain jurisdiction over this case even as it remands Plaintiffs' benefits claims to UBH for its proper consideration. See generally Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242, 249 (2010) (describing similar procedure district court apparently used in that case).

V. CONCLUSION

Because UBH abused its discretion in the manner in which it denied Plaintiffs' claims for benefits, we AFFIRM the district court's decision to reverse UBH's benefits denials. We REVERSE the district court's decision to grant Plaintiffs benefits, however, and instead REMAND this case to the district court with directions to remand Plaintiffs' benefits claims to UBH for its further, and proper, consideration. We also VACATE the district court's award of attorney's fees to Plaintiffs and remand the fee question to the district court for its further consideration.