

AN EMPLOYER'S GUIDE TO HEALTH AND DISABILITY BENEFIT CLAIMS



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

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This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Introduction

If you're an employer and you sponsor a group health or disability benefit plan covered by the Employee Retirement Income Security Act (ERISA), your plan must meet the minimum standards for benefit claims procedures set by rules issued by the Department of Labor.

Among other things, these standards include requirements for:

- Processing benefit claims;
- The timeframes for deciding claims;
- Notices of benefit denials, reductions, or terminations; and
- The standards for appeals.

If you are a fiduciary to an ERISA-covered group health or disability benefit plan (including insured and self-funded plans), you must maintain the plan's claims procedures. Even if you hire benefits professionals or insurance companies to process claims, you need to understand the requirements before selecting service providers who will be able to comply with the benefit claims standards.

This booklet addresses ERISA's claims procedures for private-sector group health and disability plans (plans sponsored by government entities and churches are not covered by ERISA). It provides a simplified explanation of the law and regulations. It is not a legal interpretation of ERISA, nor is it a substitute for the advice of a legal professional.

Informing Participants and Beneficiaries about the Plan's Claims Procedures

Every employee benefit plan must establish and maintain reasonable procedures for benefits claims. Plan administrators must provide these claims procedures to plan participants and beneficiaries when they enroll. Typically, this is done through the Summary Plan Description (SPD), a plain language explanation of the plan. The SPD informs participants of how the plan works, the benefits it provides, and how they can file a claim for benefits. Sometimes claims procedures are contained in a separate booklet that is handed out with the SPD. The SPD or claims procedure booklet must include information on where to file, what to file, and whom participants and beneficiaries can contact with questions about the plan.

If the plan is collectively bargained, the collective bargaining agreement may also include information on claim filing, grievance, and appeal procedures.

What is a Claim?

A claim for benefits is a request for a plan benefit made in accordance with the plan's procedures by a claimant (participant or beneficiary) or their authorized representative. If an authorized representative files the claim, the plan can require the claimant to complete a form to name the representative. However, in the case of a claim involving urgent care, the treating physician can automatically act as the claimant's authorized representative without having to complete a form.

Casual inquiries, including questions about plan benefits, coverage, and eligibility, are generally not considered claims for benefits.

Plans generally cannot charge any filing fees or costs for filing claims and appeals.

Plans must decide all health and disability benefit claims within a specific time limit, depending on the type of claim filed. The time limits are counted in calendar days, including weekends and holidays. These limits do not govern when the benefits must be paid or provided. Plans are required to pay or provide benefits within a reasonable time after a claim is approved. Below is a discussion of how the claims procedure rules apply to health benefits. For information on the rules that apply to disability benefits turn to page 7.

Health Benefit Claims

Types of Health Benefit Claims

There are three types of group health claims under the Department's rule – urgent care, pre-service, and post-service.

Urgent care claims are a special kind of pre-service claim that requires a quick decision because the participant or beneficiary's health would be threatened if the plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of the medical condition tells the plan that a pre-service claim is urgent, the plan must treat it as an urgent care claim.

Pre-service claims are requests for approval required before medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.

Post-service claims are all other claims for benefits under a group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment for the provided services. Most claims for group health benefits are post-service claims.

Deadline for Making an Initial Determination of a Health Benefit Claim

The timeframe for a plan to provide notice of a claim determination varies based on the type of claim filed.

CLAIM TYPE	DEADLINE FOR MAKING INITIAL DETERMINATION
Urgent care	As soon as possible, and no later than 72 hours after receiving the claim
Pre-service	Within a reasonable time period, and no later than 15 days after receiving the claim*
Post-service	Within a reasonable time period, and no later than 30 days after receiving the claim*

*Please note: A plan may extend the deadline for making a determination under specific circumstances.

Urgent care claims must be decided as soon as possible, taking into account the patient's medical needs, and no later than **72 hours** after the plan receives the claim.

If the plan needs more information, it must tell the claimant within 24 hours and give the claimant at least 48 hours to respond. Then the plan must decide the claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the claimant to supply the missing information, whichever comes first. The plan cannot extend the deadline to make the initial decision without the claimant's consent. The plan must notify the claimant that the claim has been granted or denied before the end of the allotted time. The plan may notify the claimant orally as long as it furnishes a written notification within three days after the oral notification.

Pre-service claims must be decided within a reasonable time period appropriate to the medical circumstances, and no later than **15 days** after the plan receives the claim.

The plan may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first 15 days. The plan must notify the claimant before the first 15-day period ends:

- Explaining the reason for the delay;
- Requesting any additional information; and
- Advising the claimant when it expects to make the decision.

If the plan requests more information, the claimant has at least 45 days to supply it. The plan then must decide the claim within 15 days after receiving the additional information or within 15 days of the deadline for the claimant to supply the additional information, whichever comes first. The plan cannot extend the deadline without the claimant's consent. The plan must notify the claimant in writing that the claim has been granted or denied before the deadline for the decision.

Post-service health claims must be decided within a reasonable time period, and no later than **30 days** after the plan receives the claim.

The plan may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first 30 days. However, the plan administrator must notify the claimant before the first 30-day period ends:

- Explaining the reason for the delay;
- Requesting any additional information needed; and
- Advising the claimant when the plan expects to make a decision.

If the plan requests more information, the claimant has at least 45 days to supply it. The plan must then decide the claim within 15 days after receiving the additional information or within 15 days after the deadline for the claimant to supply the additional information, whichever comes first. The plan cannot extend the deadline without the claimant's consent.

The plan must notify the claimant that the claim has been denied in whole or in part (paying anything less than 100 percent of a claim is a denial in part) before the deadline for the decision.

Health Benefit Claims Denial Notices

If a plan denies a claim, it must send a denial notice to the claimant, either in writing or electronically. The notice must include:

- Specific reasons for denial (for example, not medically necessary, not covered by the plan, or reached maximum amount of treatment permitted under the plan);
- A reference to any specific plan provisions relied upon for the denial;
- If denied for a lack of information, a description of any additional material needed and an explanation of why it's necessary;
- A description of the plan's review procedures (for example, how appeals work and/or how to initiate an appeal);
- If denied based on rules, guidelines, or protocols, either a description of the rules, guidelines, or protocols relied upon in denying the claim, or a statement that a free copy of such items will be provided upon request;
- If denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that an explanation will be provided for free upon request; and
- A description of the claimant's right to go to court to recover benefits due under the plan.

Reviewing an Appeal of a Denied Health Benefit Claim

Plans must give claimants at least 180 days to file an appeal. Appeals must be reviewed by someone new who looks at all of the information submitted and consults with qualified medical professionals

if a medical judgment is involved. This reviewer cannot be the same person who made the initial decision or that person’s subordinate, and the reviewer must give no consideration to the initial decision.

The timeframe for a plan to review appeals varies based on the type of claim filed.

CLAIM TYPE	DEADLINE FOR REVIEWING AN APPEAL
Urgent care	As soon as possible, taking into account the patient’s medical needs, and no later than 72 hours after receiving the request to review a denied claim
Pre-service	Within a reasonable time period appropriate to the medical circumstances, and no later than 30 days after receiving the request to review a denied claim*
Post-service	Within a reasonable time period, and no later than 60 days after receiving the request to review a denied claim*

*Please note: A plan may extend the timeline for reviewing an appeal with the claimant’s consent.

The plan cannot extend the deadline without the claimant’s consent. Also, there are two exceptions to these deadlines:

- **Single-employer collectively bargained plans** generally may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination, and review of benefit claims.
- **Multiemployer collectively bargained plans** have special timeframes to allow them to schedule reviews on appeal of post-service claims for the regular quarterly board of trustee meetings.

Plans can require no more than two levels of review. If a plan requires two levels of review, the maximum time period for each review generally is half of the time period permitted for one review. For example, a group health plan with one appeal level must review a pre-service claim within a reasonable period of time appropriate to the medical circumstances and no later than 30 days after the plan receives the appeal. If the plan requires two appeals, each review must be completed within 15 days for pre-service claims. If a claim on appeal is still denied after the first review, the plan must allow the claimant a reasonable period of time (but not a full 180 days) to file for the second review.

Notice of Denial of a Health Benefit Claim on Appeal

Once a plan makes a final denial of a claim on appeal, the plan must send the claimant a written notice of the decision. The notice must include:

- The specific reasons the claim was denied on appeal;
- A reference to the plan provisions on which the decision is based;
- A description of any voluntary processes the plan offers to resolve claims disputes;
- An explanation of the claimant’s right to receive documents relevant to the benefit claim (documents and records upon which the decision is based and other documents prepared or used during the process), free of charge; and
- A description of the claimant’s rights to seek judicial review of the plan’s decision.

The plan’s claims procedure must provide for a full and fair review of a benefit claim if a claimant files an appeal of the denial. In addition to following the standards outlined above, the reviewer must consult with a qualified health professional (and others as needed) when the denial is based on a determination of whether a particular treatment, drug, or other item is experimental, investigational, or not “medically necessary”. In addition, mandatory binding arbitration of claims is generally prohibited. However, non-binding arbitration is permissible if done within the required timelines.

Additional Rules for Plans Not Grandfathered Under the Affordable Care Act

Plans that are not grandfathered under the Affordable Care Act (those established, or that have made certain significant changes, after March 23, 2010) must comply with additional internal claims procedure requirements. The claims and appeal process must cover rescissions (retroactive cancellations) of coverage, as well as other denials of benefits. They, or their insurers, also must:

- Provide claimants with new or additional evidence or rationale, and a reasonable opportunity to respond to it, before making a final decision on the claim;
- Ensure that claims and appeals are adjudicated in an independent and impartial manner;
- Provide detail in all claims denial notices on the claim involved, the reason for denial (including the denial code and meaning), any available internal and external appeals processes, and consumer assistance information;
- Provide, on request, diagnosis and treatment codes (and their meanings) for any denied claim;
- Provide notices in a culturally and linguistically appropriate manner;
- Allow claimants to begin the external review process if the plan fails to follow the internal claims requirements (unless the plan’s violation is minimal); and
- Allow claimants to resubmit a claim through the internal claims process if a request for immediate external review is rejected by the external reviewer under specific circumstances.

More information on the Affordable Care Act requirements of the claims and appeal process, including model notices, can be found in Appendix A and Appendix C of the Department’s publication, *Compliance Assistance Guide – Health Benefits Coverage Under Federal Law*.

If a Claimant's Health Benefit Appeal Is Denied

Claimants normally must complete the plan's internal claim process before filing an action in court to challenge the denial of a claim for benefits. However, a claimant who believes that the plan failed to establish or follow a claims procedure consistent with the Department's rules described in this booklet may have the right to ask a court to review the benefit claim without waiting for a decision from the plan.

In addition, plans not grandfathered under the Affordable Care Act must provide for external review of claim denials by an independent party. The external review process used by the plan depends on whether the plan is self-funded or provides benefits through an insurance company.

Self-funded plans generally must comply with the procedures set by the Department of Labor. A plan may choose to refer requests for external review to an accredited Independent Review Organization, or may voluntarily comply with a state external review process if the state allows access. For more information, visit the Department of Labor's page on internal claims and appeals and external review at dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals.

Insured plans and insurance companies generally must comply with their state's external review process, if the state process includes minimum consumer standards set by the Department of Health and Human Services (HHS). If the state process does not meet these standards, group health plans and insurers may use either the accredited Independent Review Organization process or an HHS-administered Federal external review process. For the status of your state's external process, see cms.gov/CCIIO/Resources/Files/external_appeals.html.

Disability Benefit Claims

Disability benefit claims are requests for benefits where the plan must make a determination of disability to decide the claim. If benefits under a plan are conditioned on someone other than the plan making a disability determination, then the special rules for disability claims discussed below do not apply. For example, if a pension plan provides that pension benefits will be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long-term disability plan, then a claim for such pension benefits is covered by the ERISA rules for pension claims, not the rules for disability claims.

Deadline for Deciding a Disability Claim

Disability claims must be decided within a reasonable time period, but no later than **45 days** after the plan receives the claim. There are some circumstances that could extend the timeline:

IF...	AND THE PLAN...	THEN THE PLAN CAN EXTEND THE DEADLINE FOR MAKING A DECISION...
The plan needs more time to review, for reasons beyond its control	<ul style="list-style-type: none"> • Tells the claimant, within the initial 45-day period, that it needs more time, • Explains why, • Does not request any additional information needed, and • Tells the claimant when it plans to make a final decision 	Up to 30 days
	<ul style="list-style-type: none"> • Tells the claimant, within the initial 45-day period, that it needs more time, • Explains why, • Requests additional information (in which case the plan must give the claimant at least 45 days to supply the information), and • Tells the claimant when it plans to make a final decision 	Up to 30 days after receiving the information OR when the time period to provide the information ends, whichever comes first
The plan still needs more time to review after the first extension	<ul style="list-style-type: none"> • Notifies the claimant before the first extension expires 	Up to 30 days more
	<ul style="list-style-type: none"> • Notifies the claimant before the first extension expires • Requests additional information (giving the claimant at least 45 days to supply the information) 	Up to 30 days after receiving the information OR when the time period to provide the information ends, whichever comes first

For any additional extensions, the plan needs the claimant’s consent. The plan must notify the claimant whether the claim has been denied before the deadline for the decision.

Disability Claims Denial Notices

If a plan denies a claim, it must send a denial notice to the claimant, either in writing or electronically. The notice must include:

- A detailed explanation of why the claim was denied. If applicable, the notice must explain why the plan disagreed with the views of a medical professional or vocational expert (including those who treated the claimant and those whose advice was obtained by the plan), or a disability determination made by the Social Security Administration;
- A reference to the specific plan provisions on which the denial is based;
- A statement that the claimant is entitled to receive, upon request and at no cost, reasonable access to all documents relevant to the claim, and copies of them;
- The plan rules, guidelines, protocols, standards, or other similar criteria relied upon in denying the claim, or a statement that none exist; and
- A description of the plan's appeal process, including the time limits involved, and a statement of the claimant's right to pursue the claim in court if it is denied on appeal.

Reviewing an Appeal of a Denied Disability Claim

Claimants have at least 180 days to file an appeal. Appeals must be reviewed by someone new who looks at all of the information submitted and consults with qualified medical professionals if a medical judgment is involved. This reviewer cannot be the same person who made the initial decision or that person's subordinate, and the reviewer must give no consideration to the initial decision.

Disability appeals must be reviewed within a reasonable period of time, but not later than 45 days after the plan receives the request to review a denied claim. If the plan determines special circumstances justify an extension, the plan may take up to an additional 45 days to decide the appeal. However, the plan first must notify the claimant in writing during the first 45-day period, explaining the special circumstances and the date by which the plan expects to make the decision.

There are two exceptions to these time limits:

- **Single-employer collectively bargained plans** generally may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination, and review of benefit claims.
- **Multiemployer collectively bargained plans** have special timeframes to allow them to schedule reviews on appeal for the regular quarterly board of trustee meetings.

A plan cannot deny a claimant's appeal based on new or additional evidence or rationales that were not included when the benefit was first denied, unless the plan notifies the claimant and gives them a reasonable opportunity to respond before the date the plan's decision is due.

Plans can require no more than two levels of review. If a plan requires two levels of review, the maximum time period for each review generally is half of the time period permitted for one review.

For example, a plan with one appeal level must review a disability claim within a reasonable period of time and no later than 45 days after receiving the appeal. If the plan requires two appeals, both reviews must be completed within 45 days. If a claim on appeal is still denied after the first review, the plan must allow the claimant a reasonable period of time (but not a full 180 days) to file for the second review.

Notice of Denial of a Disability Claim on Appeal

Once the plan makes a final decision on the claim, it must send the claimant a written notice of the decision. The notice must include:

- A detailed explanation of why the claim was denied. If applicable, the notice must explain why the plan disagreed with the views of a medical professional or vocational expert (including those who treated the claimant and those whose advice was obtained by the plan), or a disability determination made by the Social Security Administration;
- A reference to the specific plan provisions on which the decision is based;
- Information on any additional voluntary levels of appeal;
- An explanation of the claimant's right to receive documents that are relevant to the benefit claim, free of charge;
- The plan rules, guidelines, protocols, standards, or other similar criteria relied upon in denying the claim, or a statement that none exist; and
- A description of the claimant's rights to seek judicial review of the plan's decision, including a description of any contractual limitations period that applies to the right to bring an action, and the calendar date on which the claim's contractual limitations period expires.

If a Claimant's Disability Appeal Is Denied

Normally, the claimant must complete the plan's claim process before filing an action in court to challenge the denial of a claim for benefits. However, the claimant can immediately pursue the claim in court if the plan failed to establish or does not follow the claims processing rules (unless the plan's violation is minimal). If a court rejects the request for immediate review of a denied claim, the plan must treat the claim as re-filed on appeal.

Additional Requirements for Disability Claims and Appeals

The plan must ensure that both claims and appeals are adjudicated in an independent and impartial manner. For example, a person deciding a claim, or any medical or vocational expert involved in the decision, cannot be hired, promoted, terminated or compensated based on the likelihood that person will support the denial of benefits.

If a claimant lives in a county where 10 percent or more of the population is literate only in the same non-English language, the plan must provide oral language assistance in that language and provide written notices in that language upon request. In such counties, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language assistance.

Claimants are permitted to pursue their claim in court if the plan fails to follow the claims procedure requirements (unless the plan's violation is minimal).

These rules apply also to certain rescissions (meaning a retroactive cancellation or discontinuance) of disability coverage. Rescissions for non-payment of premiums are not covered by these rules.

Resources

Employer Publications

- *Compliance Assistance - Group Health and Disability Plans Benefit Claims Procedure Regulation*
- *Understanding Your Fiduciary Responsibilities Under a Group Health Plan*
- *Compliance Assistance Guide – Health Benefits Coverage Under Federal Law*
- *Reporting and Disclosure Guide For Employee Benefit Plans*

Employee Publications

- *Filing a Claim for Your Health Benefits*
- *Filing a Claim for Your Disability Benefits*
- *Top 10 Ways to Make Your Health Benefits Work for You*
- *Life Changes Require Health Choices...Know Your Benefit Options*
- *Work Changes Require Health Choices...Protect Your Rights*

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September 2018