# FILING A CLAIM

## FOR YOUR HEALTH OR DISABILITY BENEFITS

**EMPLOYEE BENEFITS SECURITY ADMINISTRATION**
UNITED STATES DEPARTMENT OF LABOR

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## Introduction

**If you participate in a health plan or a plan that provides disability benefits, you will want to know how to file a claim for your benefits. The steps outlined below describe some of your plan's obligations and briefly explain the procedures and timelines for filing a health or disability benefits claim.**

Before you file, however, be aware of the Employee Retirement Income Security Act of 1974 (ERISA), a federal law that protects your health and disability benefits and sets standards for those who administer your plan. Among other things, the law and rules issued by the U.S. Department of Labor include requirements for the processing of benefit claims, the timeline for a decision when you file a claim, and your rights when a claim is denied.

The Affordable Care Act (also called "Obamacare") includes additional requirements for claims processing for group health plans that are "non-grandfathered." A non-grandfathered health plan is a plan that was established, or that has made certain significant changes, after March 23, 2010.

You should know that ERISA does not cover some employee benefit plans (such as those sponsored by government entities and most churches). If, however, you are one of the millions of participants and beneficiaries who depend on health or disability benefits from a private-sector employment-based plan, take a few minutes and read on to learn more.

## Reviewing Information from Your Plan

A key document related to your plan is the Summary Plan Description (SPD). The SPD is the brochure you receive when you first are covered by your employer's plan. It provides a detailed overview of the plan – how it works, what benefits it provides, and how to file a claim for benefits. It also describes your rights as well as your responsibilities under ERISA and your plan. You also can find answers to many of your questions in the Summary of Benefits and Coverage (SBC), a short, easy-to-understand summary of the benefits available under your plan and detailed information on the out-of-pocket costs for coverage. For some single-employer collectively bargained plans, you should also check the collective bargaining agreement's claim filing, grievance, and appeal procedures as they may apply to claims for health and disability benefits.

Before you apply for health or disability benefits, review the SPD to make sure you meet the plan's requirements and understand the procedures for filing a claim. Sometimes claims procedures are contained in a separate booklet that is handed out with your SPD. If you do not have a copy of your plan's SPD or claims procedures, make a written request for one or both to your plan's administrator. Your plan administrator is required to provide you with a copy.

## Filing a Claim

An important first step is to check your SPD and the SBC to make sure you meet your plan's requirements to receive benefits. Your plan might say, for example, that a waiting period must pass before you can enroll and receive benefits or that a dependent is not covered after a certain age. Also, be aware of what your plan requires to file a claim. The SPD or claims procedure booklet must include information on where to file, what to file, and whom to contact if you have questions about your plan, such as the process for providing a required pre-approval for health benefits. Plans generally cannot charge any filing fees or costs for filing claims and appeals.

If, for any reason, that information is not in the SPD or claims procedure booklet, write your plan administrator, your employer's human resource department (or the office that normally handles claims), or your employer to notify them that you have a claim. Keep a copy of the letter for your records. You may also want to send the letter by certified mail, return receipt requested, so you will have a record that the letter was received and by whom.

If it is not you, but an authorized representative who is filing the claim, that person should refer to the SPD and follow your plan's claims procedure. Your plan may require you to complete a form to name the representative. If it is an emergency situation, the treating physician can automatically become your authorized representative without you having to complete a form.

When a claim is filed, be sure to keep a copy for your records.

## Types of Claims

All health and disability benefit claims must be decided within a specific time limit, depending on the type of claim filed.

**Group health claims** are divided into three types: urgent care, pre-service and post-service claims, with the type of claim determining how quickly a decision must be made. The plan must decide what type of claim it is except when a physician determines that the urgent care is needed.

***Urgent care claim*s** are a special kind of pre-service claim that requires a quicker decision because your health would be threatened if the plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your 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 that the plan requires you to obtain before you get 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 your group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided. Most claims for group health benefits are post-service claims.

**Disability claims** are requests for benefits where the plan must make a determination of disability to decide the claim.

## Waiting For a Decision on Your Claim

As noted, ERISA sets specific periods of time for plans to evaluate your claim and inform you of the decision. The time limits are counted in calendar days, so weekends and holidays are included. These limits do not govern when the benefits must be paid or provided. If you are entitled to benefits, check your SPD for how and when benefits are paid. Plans are required to pay or provide benefits within a reasonable time after a claim is approved.

**Urgent care claims** must be decided as soon as possible, taking into account the medical needs of the patient, but no later than **72 hours** after the plan receives the claim. The plan must tell you within 24 hours if more information is needed; you will have no less than 48 hours to respond. Then the plan must decide the claim within 48 hours after the missing information is supplied or the time to supply it has elapsed. The plan cannot extend the time to make the initial decision without your consent. The plan must give you notice that your claim has been granted or denied before the end of the time allotted for the decision. The plan can notify you orally of the benefit determination so long as a written notification is furnished to you no later than three days after the oral notification.

**Pre-service claims** must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than **15 days** after the plan has received the claim. The plan may extend the time period up to an additional 15 days if, for reasons beyond the plan's control, the decision

cannot be made within the first 15 days. The plan administrator must notify you prior to the expiration of the first 15-day period, explaining the reason for the delay, requesting any additional information, and advising you when the plan expects to make the decision. If more information is requested, you have at least 45 days to supply it. The plan then must decide the claim no later than 15 days after you supply the additional information or after the period of time allowed to supply it ends, whichever comes first. If the plan wants more time, the plan needs your consent. The plan must give you written notice that your claim has been granted or denied before the end of the time allotted for the decision.

**Post-service health claims** must be decided within a reasonable period of time, but not later than **30 days** after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan may extend the time period up to an additional 15 days. However, the plan administrator has to let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan needs your consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

**Disability claims** must be decided within a reasonable period of time, but not later than **45 days** after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan can extend the timeframe up to 30 days. The plan must tell you prior to the end of the first 45-day period that additional time is needed, explaining why, any unresolved issues and additional information needed, and when the plan expects to render a final decision. If more information is requested during either extension period, you will have at least 45 days to supply it. The claim then must be decided no later than 30 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan administrator may extend the time period for up to another 30 days as long as it notifies you before the first extension expires. For any additional extensions, the plan needs your consent. The plan must give you notice whether your claim has been denied before the end of the time allotted for the decision.

If your claim is denied, the plan administrator must send you a notice, either in writing or electronically, with a detailed explanation of why your claim was denied and a description of the appeal process. In addition, the plan must include the plan rules, guidelines, or exclusions (such as medical necessity or experimental treatment exclusions) used in the decision or provide you with instructions on how you can request a copy of these documents from the plan. The notice may also include a specific request for you to provide the plan with additional information in case you wish to appeal your denial.

## Appealing a Denied Claim

Claims are denied for various reasons. Perhaps you are not eligible for benefits. Perhaps the services you received are not covered by your plan. Or, perhaps the plan simply needs more information about your claim. Whatever the reason, you have at least 180 days to file an appeal (check your SPD or claims procedure to see if your plan provides a longer period).


Use the information in your claim denial notice in preparing your appeal. You should also be aware that the plan must provide claimants, on request and free of charge, copies of documents, records, and other information relevant to the claim for benefits. The plan also must identify, at your request, any medical or vocational expert whose advice was obtained by the plan. Be sure to include in your appeal all information related to your claim, particularly any additional information or evidence that you want the plan to consider, and get it to the person specified in the denial notice before the end of the 180-day period.

## Reviewing an Appeal

On appeal, your claim 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 or a subordinate of the person who made the initial decision and the reviewer must give no consideration to that decision.

Plans have specific periods of time within which to review your appeal, depending on the type of claim.

**Urgent care claims** must be reviewed as soon as possible, taking into account the medical needs of the patient, but not later than **72 hours** after the plan receives your request to review a denied claim.

**Pre-service claims** must be reviewed within a reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after the plan receives your request to review a denied claim.

**Post-service claims** must be reviewed within a reasonable period of time, but not later than **60 days** after the plan receives your request to review a denied claim.

If a group health plan needs more time, the plan must get your consent. If you do not agree to more time, the plan must complete the review within the permitted time limit.

**Disability claims** must be reviewed within a reasonable period of time, but not later than **45 days** after the plan receives your request to review a denied claim. If the plan determines special circumstances exist and an extension is needed, the plan may take up to an additional 45 days to decide the appeal. However, before taking the extension, the plan must notify you 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. In general, single-employer collectively bargained plans may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination, and review of benefit claims. Multi-employer collectively bargained plans are given special timeframes to allow them to schedule reviews on appeal of post-service claims and disability claims for the regular quarterly meetings of their boards of trustees. If you are a participant in one of those plans and you have questions about your plan's procedures, you can consult your plan's SPD and collective bargaining agreement or contact the Department of Labor's Employee Benefits Security Administration (EBSA) at the phone number below.

Plans can require you to go through two levels of review of a denied health or disability claim to finish the plan's claims process. If two levels of review are required, the maximum time for each review generally is half of the time limit permitted for one review. For example, in the case of a group health plan with one appeal level, as noted above, the review of a pre-service claim must be completed within a reasonable period of time appropriate to the medical circumstances but no later than 30 days after the plan gets your appeal. If the plan requires two appeals, each review must be completed within 15 days for pre-service claims. If your claim on appeal is still denied after the first review, the plan has to allow you a reasonable period of time (but not a full 180 days) to file for the second review.

Once the final decision on your claim is made, the plan must send you a written explanation of the decision. The notice must be in plain language that can be understood by participants in the plan. It must include all the specific reasons for the denial of your claim on appeal, refer you to the plan provisions on which the decision is based, tell you if the plan has any additional voluntary levels of appeal, explain your right to receive documents that are relevant to your benefit claim free of charge, and describe your rights to seek judicial review of the plan's decision.

## If Your Appeal Is Denied

If the plan's final decision denies your claim, you may want to seek legal advice regarding your rights to bring an action in court to challenge the denial. Normally, you must complete your plan's claim process before filing an action in court to challenge the denial of a claim for benefits. However, if you believe your plan failed to establish or follow a claims procedure consistent with the Department's

rules described in this booklet, you may want to seek legal advice regarding your right to ask a court to review your benefit claim without waiting for a decision from the plan. You also may want to contact the nearest EBSA office about your rights if you believe the plan failed to follow any of ERISA's requirements in handling your benefit claim.

If your appeal is denied and you are in a non-grandfathered health plan, you also have the right to external review of the decision, as discussed below. To find out if your plan is not grandfathered, check the documents from your plan describing the plan's benefits. If your plan is grandfathered, it must be disclosed. If there is no disclosure in your plan's documents, your plan likely is not grandfathered.

## Additional Protections if Your Plan is Not Grandfathered under the Affordable Care Act

Non-grandfathered health plans, or insurers to those plans, must provide additional internal claims and appeal rights and a process for external review of benefit claim denials. Internal claims and appeals are your health claims or appeals of denials reviewed by your plan. These rights also apply to rescissions (retroactive cancellations) of coverage.

The additional internal claims and appeal protections include:

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

Non-grandfathered plans also must provide a process for an external review of claims denials by an independent party. The external review process used depends on whether the plan is self-funded or provides benefits through an insurance company. The notice of the denial of your claim from your plan will describe the external review process and your rights. To request an external review of your claim denial, follow the steps provided in your denial notice.

## Filing a Claim – Summary

- Check your plan's benefits and claims procedure before filing a claim. Read your SPD and SBC. Contact your plan administrator if you have questions.
- Once your claim is filed, the maximum allowable waiting period for a decision varies by the type of claim, ranging from 72 hours to 45 days. However, your plan can extend certain time periods but must notify you before doing so. Usually, you will receive a decision within this timeframe.
- If your claim is denied, you must receive a written notice, including specific information about why your claim was denied and how to file an appeal.
- You have at least 180 days to request a full and fair review of your denied claim. Use your plan's appeals procedure and be aware that you may need to gather and submit new evidence or information to help the plan in reviewing the claim.
- Reviewing your appeal can take between 72 hours and 60 days depending on the type of claim. The law and the Department's rules allow a disability plan additional time if the plan's administrator has notified you beforehand of the need for an extension. For an appeal of a health claim, the plan needs your permission for an extension. The plan must send you a written notice, telling you whether the appeal was granted or denied.
- If the appeal is denied, the written notice must tell you the reason it was denied, describe any additional appeal levels or voluntary appeal procedures offered by the plan, and contain a statement regarding your rights to seek judicial review of the plan's decision.
- You may decide to seek legal advice if your claim's appeal is denied or if the plan failed to establish or follow reasonable claims procedures. If you believe the plan failed to follow ERISA's requirements, you also may want to contact the nearest EBSA office concerning your rights under ERISA.
- If the appeal is denied and your plan is not grandfathered, the denial notice will describe your rights to independent external review of the denied claim. To request external review, follow the steps provided in the notice.

## Resources

To view this and other EBSA publications, visit the agency's Website at **dol.gov/ebsa**.

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