



FILING A CLAIM

FOR YOUR HEALTH BENEFITS



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

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

To order publications or speak with a benefits advisor, contact EBSA electronically at: **askebsa.dol.gov**.

Or call toll free: **1-866-444-3272**

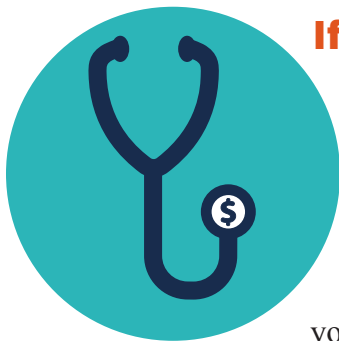
This material will be made available in alternate format to persons with disabilities upon request:

Voice phone: **(202) 693-8664**

TTY: **(202) 501-3911**

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

Introduction



If you participate in a workplace plan that provides health benefits, this booklet describes some of your plan's obligations and briefly explains the procedures and timelines for filing a health claim.

The Employee Retirement Income Security Act of 1974 (ERISA) protects your health benefits and sets standards for those who administer your plan. Among other things, the law and related rules include:

- Requirements for processing benefit claims,
- The timeline for a decision, and
- Your rights when a claim is denied.

The rules for health claims discussed in this booklet generally apply to people who receive health benefits from a private-sector employment plan. However, there are exceptions for plans sponsored by government or most religious bodies.

If you're not sure whether ERISA applies to you, contact your plan administrator for more information.

Reviewing Information from Your Plan

When you first enroll in your employer's plan, you will receive a document called the Summary Plan Description (SPD). It provides a detailed overview of the plan: how it works, what benefits it provides, how to file a claim for benefits, and any limitations that may apply. It also describes your rights and 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. If you participate in a single-employer collectively bargained plan, your claim filing, grievance, and appeal procedures may also be affected by the collective bargaining agreement.

Before you apply for benefits, review the Summary Plan Description to make sure you meet the plan's requirements and understand the claim-filing procedures. Sometimes claims procedures are contained in a separate booklet. If you do not have a copy of your plan's Summary Plan Description or claims procedures, contact your plan's administrator, who is required to provide you with a copy. Keep a photocopy or similar documentation of your request for your records.

Filing a Claim

An important first step is to check your Summary Plan Description and Summary of Benefits and Coverage 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 Summary Plan Description 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. If that information is not in the booklets, 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 an authorized representative is filing the claim on your behalf, your plan may require you to complete a form to name the representative. The authorized representative must follow the plan's claims procedure in the Summary Plan Description. In the case of a claim involving urgent care, the treating physician can automatically act as your authorized representative without you having to complete a form.

When a claim is filed, be sure to keep a copy for your records. Note: plans generally cannot charge any money for filing claims and appeals.

Types of Claims

There are three types of group health claims – urgent care, pre-service and post-service.

Urgent care claims 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 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 your 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.

Waiting For a Decision on Your Claim

ERISA sets specific time limits 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. Plans are required to pay or provide benefits within a reasonable time after a claim is approved, though ERISA does not specify a time limit. Check your Summary Plan Description for how and when benefits are paid.

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

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

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

The plan must tell you within 24 hours if more information is needed and give you 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 to supply the missing information, whichever comes first. The plan cannot extend the deadline to make the initial decision without your consent. The plan must notify you that your claim has been granted or denied before the end of the allotted time. The plan may notify you 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 if, for reasons beyond its control, the plan cannot make the decision within the first 15 days. However, the plan must notify you before the first 15-day period ends:

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

If the plan requests more information, you have 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 to supply the additional information, whichever comes first. The plan cannot extend the deadline without your consent. The plan must notify you in writing that your 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 if, for reasons beyond its control, the plan cannot make the decision within the first 30 days. However, the plan must notify you before the first 30-day period ends:

- Explaining the reason for the delay,
- Requesting any additional information needed, and
- Advising you when it expects to make the decision.

If the plan requests more information, you have 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 to supply the additional information, whichever comes first. The plan cannot extend the deadline without your consent. The plan must notify you that your 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.

If your claim is denied, the plan administrator must send you a notice, 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 provision 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 your medical circumstances, or a statement that an explanation will be provided for free upon request; and
- A description of your right to go to court to recover benefits due under the plan.



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 Summary Plan Description or claims procedure to see if your plan provides a longer period).

Use the information in your claim denial notice in preparing your appeal. The plan must provide you copies of documents, records, and other information relevant to your claim for free if you request them. You can also request the identity of 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 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 your appeal varies based on the type of claim filed.

CLAIM TYPE	DEADLINE FOR REVIEWING AN APPEAL
Urgent care	As soon as possible, taking into account your medical needs, and no more 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 more than 30 days after receiving the request to review a denied claim*
Post-service	Within a reasonable time period, and no more 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 your consent. 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 of post-service claims for the regular quarterly board of trustee meetings.

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 Summary Plan Description and collective bargaining agreement or contact the Department of Labor's Employee Benefits Security Administration (EBSA) at **1-866-444-3272**.

Plans can require two levels of review of a denied health claim to finish the plan's claims process. In such cases, 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 your appeal. If the plan requires two appeals, each review must be completed within 15 days for pre-service claims. If your appeal is still denied after the first review, the plan must allow you a reasonable period of time (but not a full 180 days) to file for the second review.

Once the plan makes a final decision on your claim, the plan must send you a written explanation of the decision. It 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 your right to receive documents relevant to your 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 your rights to seek judicial review of the plan's decision.

Additional Rules for Plans Not Grandfathered under the Affordable Care Act

The Affordable Care Act includes additional requirements for claims processing for group health plans that are not grandfathered. Plans that are not grandfathered are those established, or that have made certain significant changes, after March 23, 2010. 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 you 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 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
- Allow you 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.

In addition, plans that are 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. The claim denial notice from your plan will describe the external process and your rights. To request an external review, follow the steps provided in your denial notice.

If Your Health Benefit Appeal Is Denied

If the plan's final decision denies your claim, you may want to seek legal advice regarding your rights to challenge the denial in court. Normally, you must complete your plan's claim process before filing an action in court to challenge the denial of a claim.

However, if you believe your plan failed to establish or follow a claims procedure consistent with the Department's rules, 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.

Filing a Claim - Summary

- Check your plan's benefits and claims procedure before filing a claim. Read your Summary Plan Description and Summary of Benefits and Coverage. 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 30 days. 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 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 why 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.
- 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.
- 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 can contact EBSA to discuss.

Resources

To view this and other EBSA publications, visit dol.gov/agencies/ebsa.

To order publications or request assistance from a benefits advisor, contact us at askebsa.dol.gov or call toll free **1-866-444-3272**.



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

September 2018