

ERISA Claims and Appeals Procedures



HIAC-h15

The federal Employee Retirement Income Security Act (ERISA) sets the national standards for the claims and appeal procedures of private employer-based health plans. This means that your plan must, at the minimum, provide the protections set out in ERISA.

Summary Plan Description

Your employer must give you a Summary Plan Description (SPD), a detailed summary of your plan. It explains how your plan's claim and appeal procedures work.

Filing the original claim

Procedure. Your plan will have a claim filing procedure. The SPD outlines the procedure and the steps you must follow to file the original claim for benefits.

Timing. Your plan must tell you whether it will or will not provide the benefits within 90 days. Your plan may have an extension in special circumstances if it tells you within the first 90 days (1) that it needs an extension, (2) why it needs the extension, and (3) the date it will make its final decision. The extension can be no longer than an additional 90 days.

No decision. If your plan does not give you an answer at all (either within 90 days or within 180 days if it asked for an extension) then the claim is considered denied.

Denied claims

If your claim has been denied, then your plan must send you a written notice. The notice must tell you:

1. the specific reason for the denial
2. the plan provision on which denial is based
3. what additional information might be necessary for the plan to consider the original claim
4. how to submit the denied claim for an appeal review

Appeal procedure

Your plan must have a full and fair review procedure. Your SPD should explain how the procedure works. At the least, the plan's appeal procedure must let you or your authorized representative do the following:

1. request a review in writing

2. review pertinent documents
3. submit issues and comments in writing

Filing an appeal

Your plan may set a deadline for you to appeal its decision. This means you must submit your written request for an appeal within this time or you lose your chance to appeal. The appeals deadline must be at least 60 days from when you received notice of the claim denial.

Appeal decision. The plan must make an appeal decision no later than 60 days after it receives your notice of appeal. The plan may ask for an extension in special circumstances. If there is an extension, it must make a decision no later than 120 days after receipt of the request for review. If the plan needs an extension, it must tell you in writing.

No decision. If the plan does not send you a written decision in this time frame, then the appeal is considered denied.

Written decision. The plan's appeal decision must be given to you in writing, and it must be written in a way you can understand. The decision must give you:

1. the specific reasons for the decision
2. the specific references to the plan provision on which the decision is based

This means that you will be told where to look in your plan documents for the reason why they denied your claim.

Next steps

If the plan denies your appeal, then you may contact the Department of Labor. You may also choose to seek legal assistance. You can contact the Department of Labor at the following address:

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Ave., N.W.
Washington, D.C. 20210

You can also find ERISA information from the Department of Labor online at www.dol.gov/dol/pwba.

Fact sheet provided by the Health Information & Advocacy Center, a project of PACER Center, Inc.

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