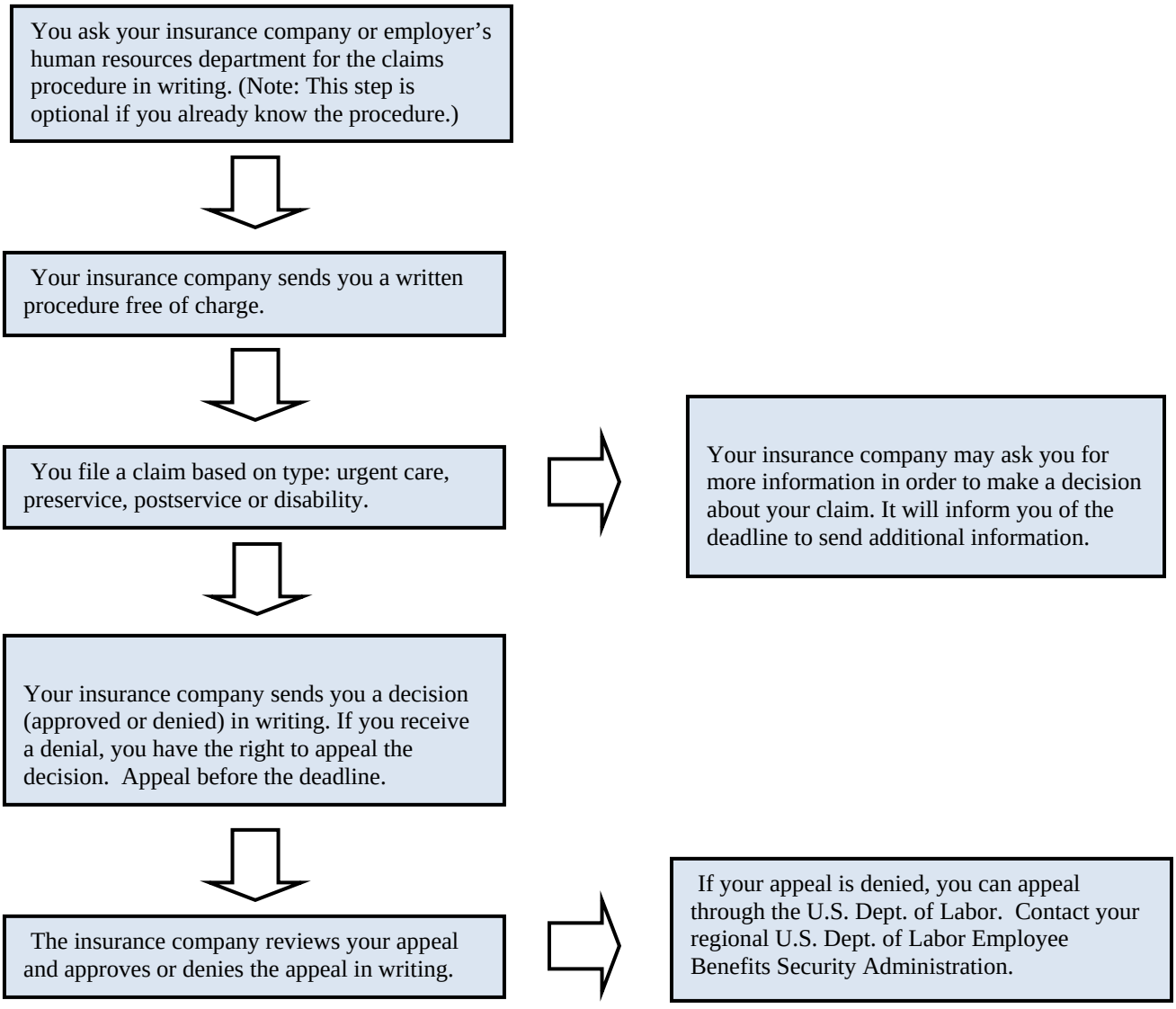
ERISA Claims and Appeals Procedures

The chart below offers a general overview of how to file insurance claims and appeals under federal Employee Retirement Income Security Act (ERISA) regulations, if your employer's insurance plan is self-insured. A more detailed explanation of ERISA claims and appeals procedures follows this chart. Contact your insurance company or your employer's human resources department for your plan's specific procedure details. This document does not serve as legal advice. More (and updated) information can be found online.



ERISA Claims and Appeals Procedures

The federal Employee Retirement Income Security Act (ERISA) sets the national standards for the claims and appeals procedures of private employer-based (self-insured) health insurance. Insurance plans or health plans through your employer must, at the minimum, provide the protections set out in ERISA. ERISA does not currently apply to individually-purchased insurance plans.

Summary Plan Description
When you qualify for self-insured insurance coverage through work, your employer must give you a Summary Plan Description (SPD), which includes details about your insurance plan.

Filing a Claim
Procedure
First, check your SPD to see if your insurance plan includes the benefits for which you are filing a claim. Your SPD also outlines requirements other than filing a claim that you must do in order to receive the health service. These requirements could include paying a co-pay, deductible or co-insurance. Your plan must have a claim-filing procedure. The SPD outlines the procedure and the steps you must follow to file a claim for benefits. You cannot be charged to file a claim. If you do not understand your benefits or the claim procedure as written in the SPD, contact the employee benefits administrator in your employer's human resources department for help. Ask for written information on the procedure.

Timing
Insurance companies make claims decisions within specific time frames, based on the type of claim filed. Your insurance plan must state whether the insurance company will or will not provide the benefits within 90 days. Your plan may include an extension for claim decisions in special circumstances, if the insurance company tells you about the extension within the first 90 days.
In addition to the general 90-day rule, ERISA sets other time frames for claims decisions, based on the type of claim. Following are the decision deadlines for specific types of claims, unless there is an extension for special circumstances:
• Urgent care claims – 72 hours
• Preservice (before treatment) claims – 15 days
• Postservice (after treatment) claims – 30 days
• Disability claims – 45 days

Extensions
Your insurance plan may have an extension in special circumstances, if the insurance company informs you in writing (1) that it needs an extension, (2) why it needs the extension, (3) what additional information it may need from you, and (4) when you can expect a decision. Like claims, extensions in special circumstances have a general 90-day maximum time limit, but the time frames may vary based on the type of claim. For both pre-service and post-service claims

decisions, the extension period is up to 15 days. Disability claims can have up to two separate 30-day extensions.
ERISA has specific time frames during which you must file additional information requested by your insurance company. These time periods vary, based on the type of claim filed. The letter you receive requesting additional information should inform you of the deadline for sending in that information.

No Decision
If your insurance company does not tell you its decision for the original claim filed, even after the extension deadline, contact the company and ask for the decision in writing. If it does not send a decision in writing, contact your regional Employee Benefits Security Administration (EBSA) office for assistance in receiving a formal approval or denial from your insurance company.

Denied Claims
If your claim has been denied, then your insurance company must send you a written or electronic notice. The notice must tell you:
1. the specific reason for the denial
2. the insurance plan's provisions on which the denial is based
3. what additional information might be necessary for the company to consider the original claim
4. how to submit the denied claim for an appeal review

Appeal Procedure
Your insurance plan must include a full and fair review procedure. If your claim is denied, you have the right to appeal the decision. Your SPD should explain how the appeal 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 relevant documents
3. Submit issues and comments in writing3

Filing an appeal
To file an appeal, follow the appeal procedure of your insurance plan. You can ask for the appeal procedure in writing from the company. Your insurance company may set a deadline for you to appeal its decision. This means you must submit your written request for an appeal before the deadline or lose your chance to appeal. The deadline for filing an appeal must be at least 60 days from when you received notice of the claim denial. Also, the letter of denial for the original claim should state the deadline for filing an appeal. You cannot be charged for filing an appeal.

Appeals decision
Like claims decisions, appeals decisions have specific time frames based on the type of original claim.
The insurance company must make an appeal decision, in general, no later than 60 days after it receives your notice of appeal. Appeals decisions, like original claims decisions, have different timelines based on the type of claim. The company may ask for an extension in special circumstances. If there is an extension, the company must make a decision no later than 120 days

after receiving your request for review. If the plan needs an extension, the company must tell you in writing.

No decision

If the time frame for the appeal expires and your insurance company does not tell you its decision for the appeal filed, contact the insurance company and ask for the decision in writing. If the company does not send a decision in writing, contact your regional Employee Benefits Security Administration (EBSA) office for assistance in receiving a formal approval or denial from your insurance provider.

Written decision

The insurance company'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's provisions on which the decision is based

This criteria means that you will be told where to look in your insurance documents for the reason the company denied your claim.

If your appeal is denied, you can appeal a second time through your insurance company, or you can file an appeal through your ESBA office, depending upon your insurance plan's appeal process.

Contact your regional EBSA office to file a complaint or an appeal after exhausting your insurance appeals process.

Next steps

If the plan denies your appeal, then you may contact the U.S. Department of Labor. You may also choose to seek legal assistance. You can contact your regional U.S. Department of Labor Employee Benefits Security Administration (EBSA) at:

U.S. Department of Labor
Employee Benefits Security Administration
2300 Main St., Suite 1100
Kansas City, MO 64108
(816) 285-1800

You can also find ERISA information through the U.S. Department of Labor online at *www.dol.gov/ebsa*.