

# **How To File A Claim For Your Benefit Plans Covered By ERISA**

## **What the Law Does**

The Employee Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and their beneficiaries who depend on benefits from private employee benefit plans. ERISA sets standards for administering these plans, including a requirement that financial and other information be disclosed to plan participants and beneficiaries and requirements for the processing of claims for benefits under the plans.

Although some employee benefit plans are not covered by the Act (such as church or government plans, etc.), if you are one of the millions of participants and beneficiaries in employee benefit plans that fall under the Act's protection, you have certain rights if your claim for benefits is denied.

Your plan must give you the reason for denial in writing and in a manner you can understand. It also must give you a reasonable opportunity for a fair and full review of the decision.

This folder outlines the steps you may take to file a claim and what to do if you are denied benefits.

## **Obtain a Copy of Your Summary Plan Description**

The first step you should take is to carefully read your plan's summary plan description. This is a document which your plan administrator must furnish you. It gives you a detailed summary of your plan - how it works, what benefits it provides, how they may be obtained and how they may be lost. The summary plan description also is required to spell out your rights and protections under ERISA.

## **Filing Your Claim**

You or your beneficiary may be required to first file a claim to receive the benefits you are entitled to under an employee welfare benefit plan or a pension plan. An employee welfare benefit plan is a plan, fund, or program which provides medical, surgical, hospital, sickness, accident, disability, death, severance, unemployment, vacation, apprenticeship, day care center, scholarship funds, pre-paid legal benefits, etc. A pension plan is a fund or program which provides retirement income to employees, or results in a deferral of income by employees for periods extending to the termination of covered employment or beyond. Each plan covered by ERISA must have procedures for filing a claim and must tell you what those procedures are. This information must be included in the summary plan description. If for any reason information concerning the filing of a claim has not been provided, you may give notification that you have a

claim by writing to an officer of your employer, or the unit where claims are normally filed, or the plan administrator.

### **What Your Plan Requires**

All plans have standards you must meet to qualify for benefits. Your pension plan will probably say that you must have worked a certain number of years and/or be a certain age before you can start receiving benefits. Some employee welfare benefit plans may require you to file a claim or notify the plan administrator immediately when you enter a hospital or see a doctor. Some plans may require that you pay a medical bill and the plan will repay you when it is presented with a copy of the bill marked "paid."

But be sure to contact your plan administrator or other plan official for complete information on filing a claim for your benefits.

### **Waiting Period**

Within 90 days after you have filed a claim for benefits, your plan must tell you whether or not you will receive the benefits. Also, if because of special circumstances your plan needs more time to examine your request, it must tell you within the 90 days that additional time is needed, why it is needed and the date by which the plan expects to render a final decision. If your claim is denied, the plan administrator must notify you in writing and explain in detail why it was denied. If you receive no answer at all in 90 days - or 180 days when an extension of time was needed - the claim is considered a denial and you can use the plan's rules for appealing the denial.

### **What To Do If Your Claim Is Denied**

Your claim may have been denied because you are not eligible for benefits under the plan. Perhaps you haven't been a participant long enough, or you are not the required age. Perhaps you needed to file additional information about your claim.

When you have been notified that your claim has been denied, your plan administrator also must tell you how to submit your denied claim for a full and fair review. You have at least 60 days (the plan may provide you with more time) in which to do this. Be sure to include all related information, particularly any additional information or evidence, and get it to the specified person and address.

### **Reviewing Your Appeal**

If review of your appeal is going to take longer than 60 days, you must be notified in writing of the delay. Except where the review is made by a committee or board of trustees which meets at least quarterly, a decision on your appeal must be made within 120 days of your appeal.

Once the final decision has been made, you must be told the reason and the plan rules upon which the decision was based. This explanation must be written in a manner that you can understand. If you do not receive a notice within the waiting time, you can assume that your claim has been denied after it was reviewed.

### **What To Do If Your Appeal Is Denied**

If you disagree with the final decision upon appeal, you may seek legal assistance. You also may wish to get in touch with the Department of Labor concerning your rights under ERISA.

#### **Know Your Plan**

By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So know your plan, what it requires of you, how to become eligible for its benefits, and what steps you can take to assure that you will receive your earned benefits.

#### **Summary of Steps**

- File claim for benefits with person designated by plan to receive claims. Check your benefits with your plan administrator.
- Benefits approved. Payment will be made. Or;
- File claim for benefits with person designated by plan to receive claims. Check your benefits with your plan administrator.
- Wait for reasonable time, usually 90 days, for outcome of claim. If no decision, and the plan did not extend the period based on special circumstances, you may consider claim denied.
- Request review of your claim. Explanation is required for a denied claim.
- You may file claim for full and fair review. Be sure and include all related information, especially new evidence or information.
- If appeal review will take longer than 60 days you must be notified. Generally, a decision must be made within 120 days of your appeal.
- If you have not received notice within time set, you can assume appeal denied. You may seek legal assistance or you may wish to get in touch with the nearest EBSA office concerning your rights under ERISA.