

**U.S. Department of Labor****Employee Benefits
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FAQs About The Benefit Claims Procedure Regulation

A-1: Does the regulation apply to benefit claims filed by enrollees in federal programs, such as Medicare and Medicaid, or to federal employees and their families covered under the Federal Employees Health Benefits Program (FEHBP)?

No. The regulation establishes requirements only for employee benefit plans that are covered under ERISA. See ERISA sections 3(1) and 3(2). Such plans are typically benefit programs provided by private-sector employers for their employees (or by unions, acting either independently or jointly with employers, for their members). Government programs, whether federal, state, or local, that are not related to employment, such as Medicaid and Medicare, are not covered by these claims procedure rules; neither are government-sponsored benefit programs for governmental employees, such as the FEHBP or benefit plans provided by state or local governments to their own employees. Such plans have their own specific rules for claims procedures, which may derive from other federal law (for federal programs) or from state or local law.

A-2: Does the regulation apply to benefit claims filed by persons who are both enrollees in Medicare + Choice programs and participants in an ERISA plan?

The regulation applies only to benefits provided under an ERISA plan that are outside the scope of what is regulated by the Medicare program. Benefits provided under ERISA plans vary from plan to plan based on plan design. When a benefit is provided under an ERISA plan pursuant to a separate group arrangement between the Medicare + Choice organization and the employer (or employee organization), even though the benefit is only available to enrollees in a Medicare + Choice program, we have been advised by HHS that the benefit would be outside the scope of what is regulated by the Medicare program. Claims for such benefits would be subject to the provisions of the regulation. The primary source of information about these ERISA benefits is the summary plan description for the plan, which is available on request from the plan administrator. On the other hand, benefits that are covered under a Medicare + Choice contract (whether they are Medicare benefits, additional benefits paid for by Medicare, or supplemental benefits paid for through a premium charged to all enrollees) are subject to the Medicare + Choice rules for organization determinations, appeals, and grievances under 42 CFR 422 and not the provisions of the regulation. See question A-1. A person who is covered by a Medicare + Choice program and wants more information on how these Medicare + Choice rules apply to his or her coverage should call 1.800.Medicare. He or she may also want to consult their Medicare Regional Office and 1.800.Medicare can assist them in contacting the appropriate office.

A-3: Does the regulation apply to a request for a determination whether an individual is eligible for coverage under a plan?

The regulation applies to coverage determinations only if they are part of a claim for benefits. The regulation, at § 2560.503-1(e), defines a claim for benefits, in part, as a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A claim for group health benefits includes pre-service claims (§ 2560.503-1(m)(2)) and post-service claims (§ 2560.503-1(m)(3)). If an individual asks a question concerning eligibility for coverage under a plan without making a claim for benefits, the eligibility determination is not governed by the claims procedure rules. If, on the other hand, the individual files a claim for benefits in accordance with the plan's reasonable procedures, and that claim is denied because the individual is not eligible for coverage under the plan, the coverage determination is part of a claim and must be handled in accordance with the claims procedures of the plan and the requirements of the regulation. See 65 FR at 70255.

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A-4: Does the regulation apply to a request for prior approval of a benefit or service when such prior approval is not required under the terms of the plan?

No. If the plan does not require prior approval for the benefit or service with respect to which the approval is being requested, the request is not a claim for benefits (§ 2560.503-1(e)) governed by the regulation. The regulation defines pre-service claim by reference to the plan's requirements, not the claimant's decision to seek the medical care, nor the doctor's decision to provide care. Thus, in the absence of any plan requirement for prior approval, mere requests for advance information on the plan's possible coverage of items or services or advance approval of covered items or services do not constitute pre-service claims under the regulation. See § 2560.503-1(m)(2).

A-5: Is a plan required to treat all questions regarding benefits as claims for benefits under the plan?

No. The regulation does not govern casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of a plan. On the other hand, a group health plan that requires the submission of pre-service claims, such as requests for preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis for concluding that the inquirer is attempting to file or further a claim for benefits, although not acting in compliance with the plan's claim filing procedures. In such a case, the regulation requires the plan to inform the individual of his or her failure to file a claim and the proper procedures to be followed. Specifically, this type of notification is required where there is a communication by a claimant or authorized representative (e.g., attending physician) that is received by a person or organizational unit customarily responsible for handling benefit matters (e.g., personnel office) and that communication names the specific claimant, specific medical condition or symptom and a specific treatment, service, or product for which approval is requested. Under the regulation, notice must be furnished as soon as possible, but not later than 24 hours in the case of urgent care claims or 5 days in the case of non-urgent claims. Notice may be oral, unless a written notification is requested. See § 2560.503-1(c)(1).

A-6: Do the requirements applicable to group health plans apply to dental benefits offered as a stand-alone plan or as part of a group health plan?

Yes, in both cases. The regulation defines group health plan as an employee welfare benefit plan within the meaning of ERISA section 3(1) to the extent that such plan provides medical care within the meaning of section 733(a) of ERISA. See § 2560.503-1(m)(6). Section 733(a)(2) defines medical care, in part, to mean the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body. Accordingly, for purposes of the claims procedure rules, the provision of dental benefits, either as part of a larger welfare plan, or as a stand-alone plan, would be subject to the requirements of the regulation applicable to group health plans.

A-7: Do the requirements applicable to group health plans apply to prescription drug benefit programs offered as a stand-alone plan or as part of a group health plan?

Yes, in both cases. Prescription drug benefits would, like dental benefits, constitute medical care within the meaning of Section 733(a)(2). See question A-6. Accordingly, the provision of prescription drug benefits, either as a stand-alone plan, or as part of a group health plan, would be subject to the requirements of the regulation applicable to group health plans. Whether, and under what circumstances, specific practices permitted under the plan, such as the submission of a prescription to a pharmacy or pharmacist, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan.

A-8: Do the requirements applicable to group health plans apply to contractual disputes between health care providers (e.g., physicians, hospitals) and insurers or managed care organizations (e.g., HMOs)?

No, provided that the contractual dispute will have no effect on a claimant's right to benefits under a plan. The regulation applies only to claims for benefits. See questions A-3, A-4, A-5. The regulation does not apply to requests by health care providers for

payments due them -- rather than due the claimant -- in accordance with contractual arrangements between the provider and an insurer or managed care organization, where the provider has no recourse against the claimant for amounts, in whole or in part, not paid by the insurer or managed care organization.

The following example illustrates this principle. Under the terms of a group health plan, participants are required to pay only a \$10 co-payment for each office visit to a preferred provider doctor listed by a managed care organization that contracts with such doctors. Under the preferred provider agreement between the doctors and the managed care organization, the doctor has no recourse against a claimant for amounts in excess of the co-payment. Any request by the doctor to the managed care organization for payment or reimbursement for services rendered to a participant is a request made under the contract with the managed care organization, not the group health plan; accordingly, the doctor's request is not a claim for benefits governed by the regulation.

On the other hand, where a claimant may request payments for medical services from a plan, but the medical provider will continue to have recourse against the claimant for amounts unpaid by the plan, the request, whether made by the claimant or by the medical provider (e.g., in the case of an assignment of benefits by the claimant) would constitute a claim for benefits by the claimant. For information on authorized representatives of claimants. See questions B-1, B-2, B-3.

A-9: What benefits are disability benefits subject to the special rules applicable under the regulation for disability claims?

A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan conditions its availability to the claimant upon a showing of disability. It does not matter how the benefit is characterized by the plan or whether the plan as a whole is a pension plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the regulation. As the department stated in the preamble to the regulation, 65 FR at 70247, n.4, where a single plan provides more than one type of benefit, it is the department's intention that the nature of the benefit should determine which procedural standards apply to a specific claim, rather than the manner in which the plan itself is characterized. Accordingly, plans, including pension plans, that provide benefits conditioned upon a determination of disability must maintain procedures for claims involving such benefits that comply with the requirements of the regulation applicable to disability claims, including the requirements for de novo review, the consultation requirement for medical judgments, the limit on appeal levels, the time limits for deciding disability claims, and the disclosure requirements in connection with extensions of time.

However, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. For example, if a pension plan provides that pension benefits shall be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long term disability plan, a claim for pension benefits based on the prior determination that the claimant is disabled would be subject to the regulation's procedural rules for pension claims, not disability claims.

A-10: Do the time frames in these rules govern the time within which claims must be paid?

No. While the regulation establishes time frames within which claims must be decided, the regulation does not address the periods within which payments that have been granted must be actually paid or services that have been approved must be actually rendered. Failure to provide services or benefit payments within reasonable periods of time following plan approval, however, may present fiduciary responsibility issues under Part 4 of title I of ERISA.

A-11: When a group health plan participant presents a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of such plan and with respect to which the pharmacy exercises no discretion on

behalf of the plan, does the regulation require that the presentation of the prescription be treated as a claim for benefits?

No. As indicated in question A-7, whether, and under what circumstances, specific practices permitted under a plan, such as the presentation of a prescription to a pharmacy, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan. In this regard, a claim for benefits is defined in § 2560.503-1(e) to mean a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. Accordingly, whether, and to what extent, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the plan will constitute a request for a plan benefit will be determined by reference to the plan's procedures for filing benefit claims.

It is not uncommon for group health plans to have arrangements with preferred or network providers (e.g., doctors, physical therapists, pharmacies, optometrists) to provide medical care-related services or products at a predetermined cost to covered plan participants and with respect to which the providers exercise no discretion on behalf of the plan. It is the view of the department that neither the statute nor the claims procedure regulation requires that a plan treat interactions between participants and preferred or network providers under such circumstances as a claim for benefits governed by the regulation. Moreover, if the pharmacy refuses to fill the prescription absent payment of the entire cost by the participant, the regulation does not require that this refusal be treated as an adverse benefit determination under the regulation. It should be noted, however, that where a plan provides such benefits the plan must maintain a reasonable procedure, in accordance with the regulation, for processing claims of participants relating to such benefits.

A-12: Does the regulation apply to benefit claims filed by participants in top hat plans, e.g., plans that are unfunded and maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees?

Yes. The regulation establishes requirements for all employee benefit plans that are covered under Part 5 of ERISA, which would include top hat plans. Certain top hat plans are specifically excluded from parts of ERISA (see, e.g., sections 201(2); 301(a)(3); 401(a)(1)), but that exclusion does not apply to section 503, under which the regulation was promulgated. In this regard, paragraph (b)(2) of the regulation requires that a description of the plan's claims procedures must be included as part of the plan's summary plan description meeting the requirements of 29 CFR § 2520.102-3. Where a top hat plan is not required to furnish summary plan descriptions, pursuant to 29 CFR §§ 2520.104-23 or 2520.104-24, such plan may satisfy the requirements of paragraph (b)(2) of the regulation by taking steps reasonably designed to ensure that participants in such plans are made aware of the existence of the plan's claims procedures in conjunction with enrollment in the plan and how to obtain such procedures upon request.

A-13: Would a determination of disability for purposes of receiving a premium waiver under a contributory life insurance plan be governed by the special rules applicable to disability benefits under the claims procedure regulation?

Yes. A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan conditions availability of the benefit on a showing of disability. As noted in question A-9, however, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. The department notes that the inclusion of a premium waiver in a plan that is not otherwise covered by ERISA would not, in and of itself, cause the plan to become subject to the regulation.

B-1: May a plan require that a claimant complete and file a form identifying any person authorized to act on his or her behalf with respect to a claim?

Yes, with one exception. The regulation provides that a reasonable claims procedure may not preclude an authorized representative of a claimant from acting on behalf of a claimant

with respect to a benefit claim or appeal of an adverse benefit determination. The regulation also provides, however, that a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. Completion of a form by the claimant identifying the authorized representative would be one method for making such a determination.

The one exception is where a claim involves urgent care. In such instances, a plan must, without regard to the plan's procedures for identifying authorized representatives, permit a health care professional with knowledge of the claimant's medical condition (e.g., a treating physician) to act as the authorized representative of the claimant. This exception is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the claimant is unable to act on his or her own behalf. See § 2560.503-1(b)(4).

B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant's authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

B-4: What kind of administrative processes and safeguards must a plan have in place to ensure and verify appropriately consistent decision making?

The department did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan. The department believes that prudent plan administration requires ensuring that similarly situated claims are, under similar circumstances, decided in a consistent manner. Consistency in the benefit claims determinations might be ensured by applying protocols, guidelines, criteria, rate tables, fee schedules, etc. Consistent decision making might be ensured and verified by periodic examinations, reviews, or audits of benefit claims to determine whether the appropriate protocols, guidelines, criteria, rate tables, fee schedules, etc. were applied in the claims determination process. See § 2560.503-1(b)(5).

B-5: For purposes of furnishing relevant documents to a claimant, what kind of disclosure is required to demonstrate compliance with the administrative processes and safeguards required to ensure and verify appropriately consistent decision making in making the benefit determination?

What documents will be required to be disclosed will depend on the particular processes and safeguards that a plan has established and maintains to ensure and verify appropriately consistent decision making. See 65 FR at 70252. The department does not anticipate new documents being developed solely to comply with this disclosure