CLAIMS AND APPEALS FOR DISABILITY BENEFITS

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	Disability Claims (through April 1, 2018)	Disability Claims (after April 1, 2018)
1. Notice of improperly filed claim	No provision.	No change.
2. Deadline for decision on claim	A "reasonable period" not to exceed 45 days after receiving claim. 29 CFR §2560.503-1(f)(3).	No change.
3. Extension of timeframe for decision on claim	Two 30-day extensions, if necessary due to matters beyond the control of the plan administrator. The plan administrator must notify the claimant of the extension before the original deadline. An extension notice must explain: (1) the circumstances requiring delay; (2) the standards for entitlement for a benefit; (3) unresolved issues; (4) information needed to resolve those issues; and (5) the date the plan administrator expects to decide the claim. 29 CFR §2560.503-1(f)(3).	No change.
4. Deadline for claimant to supply missing information	The claimant must be given at least 45 days to supply the needed information. 29 CFR §2560.503-1(f)(3). The period that the claimant takes to produce the needed information does not count against the period for deciding the claim. 29 CFR §2560.503-1(f)(4).	No change.
5. Standard for deciding claim	The plan is supposed to have administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that plan provisions are applied consistently with respect to similarly situated claimants. 29 CFR §2560.503-1(b)(5).	The plan is supposed to have administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that plan provisions are applied consistently with respect to similarly situated claimants. 29 CFR §2560.503-1(b)(5) [same as 2000 rule]. NEW The plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits. 29 CFR §2560.503-1(b)(7).

	Disability Claims (through April 1, 2018)	Disability Claims (after April 1, 2018)
6. Form of notice of decision on claim	Notice should include: (1) reasons for denial; (2) references to the specific plan provisions on which the denial is based; (3) a description of additional information needed to perfect the claim and an explanation of why the information is needed; and (4) an explanation of the appeal procedures, including a statement that the claimant can file suit under §502(a) of ERISA following an adverse decision on an appeal. 29 CFR §2560.503-1(g)(1)(i), (ii), (iii), and (iv).	No change.
7. Form of notice of decision on claim -- *continued*	Notice should include: (5) If an internal rule, guideline, protocol, or other similar criterion was relied upon, either: (a) the specific rule, guideline, protocol, or other similar criterion, or (b) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request. 29 CFR §2560.503-1(g)(1)(v)(A).	Notice should include: (5) Either: (a) the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination; or (b) a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. 29 CFR §2560.503-1(g)(1)(vii)(C).
8. Form of notice of decision on claim -- *continued*	Notice should include: (6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided free of charge upon request. 29 CFR §2560.503-1(g)(1)(v)(B).	Notice should include: (6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided free of charge upon request. 29 CFR §2560.503-1(g)(1)(vii)(B) [same as 2000 rule but different cite]. NEW (7) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. 29 CFR §2560.503-1(g)(1)(vii)(D). Whether a document, record, or other information is relevant to a claim for benefits is determined by reference to 29 CFR §2560.503-1(m)(8). 29 CFR §2560.503-1(g)(1)(vii)(D).

	Disability Claims (through April 1, 2018)	Disability Claims (after April 1, 2018)
9. Form of notice of decision on claim -- *continued*	No provision.	Notice should include: (8) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration. 29 CFR §2560.503-1(g)(1)(vii)(A).
10. Form of notice of decision on claim -- *continued*	No provision.	Notices must be provided in a culturally and linguistically appropriate manner. This includes: (a) customer service in the applicable non-English language; (b) a statement in the applicable non-English language, prominently displayed on notices, explaining how to access language services; and (c) notices in the applicable non-English language, upon request. 29 CFR §2560.503-1(g)(1)(viii), 29 CFR §2560.503-1((j)(7), and 29 CFR §2560.503-1(o). Applicable non-English language is based on county of residence.
11. Identification of medical expert	If the claimant requests it in connection with an adverse benefit determination, the plan administrator must identify the medical (or vocational) experts whose advice was obtained (without regard to whether the advice was relied upon in making the determination). 29 CFR §2560.503-1(h)(4) incorporating (h)(3)(iv).	No change.
12. Deadline for claimant to file appeal	180 days after notice of the denial of the claim. 29 CFR §2560.503-1(h)(4) incorporating (h)(3)(i).	No change.

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13. New evidence or rationale for decision	No provision.	Before the plan can issue an adverse benefit determination on appeal, the plan must provide the claimant, automatically and free of charge: (a) any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; and (b) any new or additional rationale that is the basis for an adverse benefit determination. The evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided so as to give the claimant a reasonable opportunity to respond prior to that date. 29 CFR §2560.503-1(h)(4)(i) and (ii).
14. Standard for deciding appeal	The fiduciary must conduct a "full and fair" review. 29 CFR §2560.503-1(h)(1). The fiduciary must consider all information submitted by the claimant, regardless of whether the information was part of the original claim. 29 CFR §2560.503-1(h)(2)(iv).	No change.
15. Standard for deciding appeal -- *continued*	The appeal must be to a fiduciary who neither made the initial benefit denial nor is the subordinate of the person who made that denial. 29 CFR §2560.503-1(h)(4), incorporating (h)(3)(ii).	No change.
16. Standard for deciding appeal -- *continued*	The fiduciary deciding an appeal must give no deference to the initial claim denial. 29 CFR §2560.503-1(h)(4), incorporating (h)(3)(ii). For issues involving medical judgment, the fiduciary must consult with a health care professional. The health care professional cannot be the same health care professional who was consulted for the initial benefit determination (and cannot be the subordinate of the health care professional consulted for the initial benefit determination). 29 CFR 2560.503-1(h)(4) incorporating (h)(3)(iii) and (v).	No change.
17. Deadline for decision on appeal	A "reasonable" period not to exceed 45 days after the receipt of the appeal. 29 CFR §2560.503-1(i)(3)(i).	No change.

	Disability Claims (through April 1, 2018)	Disability Claims (after April 1, 2018)
18. Extension of timeframe for decision on appeal	A single 45-day extension if needed for special circumstances. The plan administrator must notify the claimant of the extension before the original deadline. An extension notice must explain: (1) the circumstances requiring delay; and (2) the date the plan administrator expects to decide the appeal. 29 CFR §2560.503-1(i)(3)(i). If the claimant is given additional time to produce needed information, the time that the claimant takes to produce the needed information does not count against the period for deciding the claim. 29 CFR §2560.503-1(i)(4).	No change.
19. Multiemployer plan -- deadline for plan administrator's decision on appeal by board of trustees	Decision should be made at the meeting following the plan's receipt of the appeal, unless the plan receives the appeal within 30 days before the next meeting. In that case, the decision should be made at the second meeting following the plan's receipt of the appeal. 29 CFR §2560.503-1(i)(3)(ii).	No change.
20. Multiemployer plan -- Extensions permitted	If special circumstances (such as the need to hold a hearing) require further extension for procession, the decision can be made no later than the third meeting following the plan's receipt of the appeal. The plan administrator must notify the claimant of the extension before the original deadline expires. An extension notice must explain: (1) the circumstances requiring delay; and (2) the date the plan administrator expects to decide the appeal. 29 CFR §2560.503-1(i)(3)(ii). If the claimant is given additional time to produce needed information, the time that the claimant takes to produce the needed information does not count against the period for deciding the claim. 29 CFR §2560.503-1(i)(4).	No change.
21. Multiemployer plan -- Timing of notice of decision on appeal	The plan administrator should notify the claimant of the decision on the appeal as soon as possible (and no more than 5 days) after the decision is made. 29 CFR §2560.503-1(i)(3)(ii).	No change.
22. Form of notice of decision on appeal	Notice should include: (1) reasons for the decision; (2) references to specific plan provisions on which the decision is based; (3) statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;	No change.

	Disability Claims (through April 1, 2018)	Disability Claims (after April 1, 2018)
23. Form of notice of decision on appeal -- *continued*	Notice should include: (4) if applicable, a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures; 29 CFR §2560.503-1(j)(4).	No change.
24. Form of notice of decision on appeal -- *continued*	Notice should include: (5) a statement of the claimant's right to bring an action under section 502(a) of ERISA; 29 CFR §2560.503-1(j)(4). Although not required by the regulation, we recommend including: (a) the period during which suit may be brought; and (b) any restrictions on venue.	Notice should include: (5) a statement of the claimant's right to bring an action under section 502(a) of ERISA; 29 CFR §2560.503-1(j)(4)(i). [same as 2000 rule]. NEW The statement of the claimant's right to bring an action under section 502(a) of the Act shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim. 29 CFR §2560.503-1(j)(4)(ii). Although not required by the regulation, we recommend including any restrictions on venue.
25. Form of notice of decision on appeal -- *continued*	Notice should include: (6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either: (a) the specific rule, guideline, protocol, or other similar criterion; or (b) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request. 29 CFR §2560.503-1(j)(1)-(5).	Notice should include: (6) Either: (a) the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination; or (b) a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. 29 CFR §2560.503-1(j)(6)(iii).
26. Form of notice of decision on appeal -- *continued*	Notice should include: (7) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; or (b) a statement that such explanation will be provided free of change upon request. 29 CFR §2560.503-1(j)(5)(ii).	Notice should include: (7) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; or (b) a statement that such explanation will be provided free of charge upon request. 29 CFR §2560.503-1(j)(6)(ii) [same as 2000 rule but different cite].

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27. Form of notice of decision on appeal -- *continued*	No provision.	Notice should include: (8) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration. 29 CFR §2560.503-1(j)(6)(i).
28. Form of notice of decision on appeal -- *continued*	No provision.	Notices must be provided in a culturally and linguistically appropriate manner. This includes: (a) customer service in the applicable non-English language; (b) a statement in the applicable non-English language, prominently displayed on notices, explaining how to access language services; and (c) notices in the applicable non-English language, upon request. 29 CFR §2560.503-1(g)(1)(viii), 29 CFR §2560.503-1((j)(7), and 29 CFR §2560.503-1(o). Applicable non-English language is based on county of residence.
29. Deemed exhaustion	No provision.	If the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan (except for de minimis violations). If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. 29 CFR §2560.503-1(l)(2).
30. Explanation of rules in SPD	"All" claims procedures and the applicable time frames must be described in an SPD. 29 CFR §2560.503-1(b)(2).	No change.
31. Effective date	Claims for disability benefits filed on and after January 1, 2002 through April 1, 2018.	Claims for disability benefits filed after April 1, 2018. 29 CFR §2560.503-1(p)(3).

Note: Effective for claims filed after April 1, 2018, a rescission of disability benefit coverage is an appealable adverse benefit determination, regardless of whether it impacts pending claims. 29 CFR §2560.503-1(m)(4)(ii) [effective date 29 CFR §2560.503-1(p)(3)]. Although a rescission is an adverse benefit determination, a disability plan is not subject to the ACA prohibition on rescission in the absence of fraud or a material misrepresentation of material fact.