LUSE GORMAN

attorneys

March 9, 2018

New Disability Claims Procedures Rule Takes Effect April 2, 2018

The Department of Labor has issued a new final rule (the "Rule") that will apply to certain disability claims filed on and after April 2, 2018. The Rule covers all employee benefit plans that are subject to the Employee Retirement Income Security Act of 1974, and provide a benefit upon a determination of disability. The types of plans affected include health and welfare plans, pension plans, tax-qualified retirement plans, "top hat" plans and nonqualified deferred compensation plans.

The Rule includes an exception for plans in which the determination of disability is made solely by an independent third party, such as the Social Security Administration or the plan sponsor's long-term disability insurance provider.

The Rule applies when denying a claim for disability benefits. Some of the new requirements include:

- Providing more complete disclosures in benefit denial notices;
- Giving the claimant an opportunity to review and respond to new information; and
- Providing notices in the appropriate non-English language for claimants in certain counties.

If the disability claims procedures are not strictly adhered to, a claimant will be deemed to have exhausted all internal review processes and will have the immediate right to take the claim to court.

To ensure that plans comply with the Rule, we are recommending that employers (1) execute an addendum to existing claims procedures set forth in their applicable tax-qualified or non-qualified plans; (2) approve the addendum by resolution of the board of directors or the applicable committee; and (3) send a letter to plan participants notifying them of the new procedures. Please see the attached items for a form disability claims procedures addendum, form board resolution, and form letter to participants.

If you would like to know more about the Rule, its requirements, and how to comply, please contact one of the attorneys listed below:

- Beverly J. White (202)-274-2005
- Thomas P. Hutton (202)-274-2027
- Jeffrey M. Cardone (202)-274-2033
- D. Max Seltzer (202)-274-2038

ADDENDUM TO PLAN CLAIMS PROCEDURE

This Addendum is effective for disability claims made on or after April 2, 2018 (or if later, the first day on which the disability claims procedures regulation issued by the Department of Labor ("DOL") at 29 C.F.R. Section 2560.503-1 are implemented by the DOL), and will be used by the Plan Administrator to adjudicate disability claims made under the plan where an independent determination of disability by the Plan Administrator is required. This Addendum is to be recognized as an addition to, and not a replacement of, the plans' existing Claims Procedures. This Addendum applies to the plans set forth in Exhibit A attached hereto (each separately and individually referred to as the "Plan").

Initiating a Written Claim. If the claim relates to disability benefits, the Plan Administrator shall 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.

Timing of Plan Administrator Response. If the claim relates to a determination of disability, and the claim requires an independent determination by the Plan Administrator of a Participant's disability status, the Plan Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but no later than forty-five (45) days after receipt of the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Claimant will be notified, within forty-five (45) days after the Plan Administrator receives the claim, of those circumstances and of when the Plan Administrator expects to make its decision, but not beyond seventy-five (75) days. If, prior to the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to one hundred five (105) days, provided that the Plan Administrator notifies the Claimant of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. The extension notice shall specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

Notice of Decision. In the case of an adverse benefit determination with respect to disability benefits, on the basis of the Plan Administrator's independent determination of the Participant's disability status, the Plan Administrator will provide a notification in a culturally and linguistically appropriate manner (as described in Department of Labor Regulation Section 2560.503-1(o)) that shall set forth:

(i) The specific reasons for the denial;

(ii) A reference to the specific provisions of the Plan or insurance contract on which the denial is based;

(iii) Notice that the Claimant has a right to request a review of the claim denial and an explanation of the Plan's review procedures and the time limits applicable to such procedures;

(iv) A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and a description of any time limit that applies under the Plan for bringing such an action;

(v) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) 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

(3) A disability determination regarding the Claimant presented by the Claimant made by the Social Security Administration.

(vi) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(viii) 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. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by Department of Labor Regulation Section 2560.503-1(m)(8).

Review Procedure. If the initial claim is for disability benefits, and the claim requires an independent determination by the Plan Administrator of a Participant's disability status, and the Plan Administrator denies the claim, in whole or in part, the Claimant shall have the opportunity for a full and fair review by the Plan Administrator of the denial, as follows:

(i) Prior to such review of the denied claim, the Claimant shall be given, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim, or any new or additional rationale, 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, to give the Claimant a reasonable opportunity to respond prior to that date.

(ii) The Plan Administrator shall respond in writing to such Claimant within forty-five (45) days after receiving the request for review. If the Plan Administrator determines that special circumstances require additional time for processing the claim, the Plan Administrator can extend the response period by an additional forty-five (45) days by notifying the Claimant in writing, prior to the end of the initial 45-day period that an additional period is required. The notice of extension must set forth the special circumstances and the date by which the Plan Administrator expects to render its decision.

(iii) The Claimant shall be given the opportunity to submit issues and written comments to the Plan Administrator, as well as to review and receive, without charge, all relevant (as defined in applicable ERISA regulations) documents, records and other information relating to the claim. The reviewer shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(iv) In considering the review, the Plan Administrator shall take into account all comments, documents, records and other information submitted by the Claimant

relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additional considerations shall be required in the case of a claim for disability benefits. For example, the claim will be reviewed by an individual or committee who did not make the initial determination that is subject of the appeal, nor by a subordinate of the individual who made the determination, and the review shall be made without deference to the initial adverse benefit determination. If the initial adverse benefit determination was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involving the medical judgment. The health care professional who is consulted on appeal will not be the same individual who was consulted during the initial determination or the subordinate of such individual. If the Plan Administrator obtained the advice of medical or vocational experts in making the initial adverse benefits determination (regardless of whether the advice was relied upon), the Plan Administrator will identify such experts.

Notice of Decision after Review. In the case of an adverse benefit determination with respect to disability benefits, on the basis of the Plan Administrator's independent determination of the Participant's disability status, the Plan Administrator will provide a notification in a culturally and linguistically appropriate manner (as described in Department of Labor Regulation Section 2560.503-1(o)) that shall set forth:

(i) The Plan Administrator's decision;

(ii) The specific reasons for the denial;

(iii) A reference to the specific provisions of the Plan or insurance contract on which the decision is based;

(iv) 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 (as defined in applicable ERISA regulations) to the Claimant's claim for benefits;

(v) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures;

(vi) A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) which shall 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;

(vii) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) 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

(3) A disability determination regarding the Claimant presented by the Claimant made by the Social Security Administration.

(viii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(ix) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Exhaustion of Remedies. A Claimant must follow the claims review procedures under this Plan and exhaust his or her administrative remedies before taking any further action with respect to a claim for benefits.

Failure of Plan to Follow Procedures. In the case of a claim for disability benefits, if the Plan fails to strictly adhere to all the requirements of this claims procedure with respect to a disability claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan, and shall be entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim, except where the violation was: (a) de minimis; (b) non-prejudicial; (c) attributable to good cause or matters beyond the Plan's control; (d) in the context of an ongoing good-faith exchange of information; and (e) not reflective of a pattern or practice of non- compliance. The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies to be deemed exhausted. If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

Rescission of Disability Coverage. A rescission of disability coverage (a cancellation or discontinuance of coverage that has a retroactive effect) with respect to a participant or beneficiary shall constitute an adverse benefits determination and thereby trigger the Plan’s appeals procedures, except to the extent that such rescission of coverage is attributable to the failure to timely pay required premiums or contributions towards the cost of coverage.

Date: _____

_____

Signature of Plan Administrator or Authorized Officer

Exhibit A

RESOLUTIONS OF THE BOARD OF DIRECTORS
OF
[EMPLOYER]

WHEREAS, the Board of Directors (the "Board") of ["EMPLOYER"] (the "Bank") has adopted the tax-qualified and non-qualified employee benefit plans, as amended from time to time, set forth in Exhibit A (as amended, the "Plans"); and

WHEREAS, the Department of Labor recently finalized regulations for welfare and retirement plans in order to provide procedural protections and safeguards that are aimed at providing full and fair claims procedures for disability benefit claims that are adjudicated by the plan sponsor or other plan fiduciary; and

WHEREAS, the regulations require employers sponsoring tax-qualified plans and non-qualified plans that provide disability benefits to implement procedures for the adjudication of disability benefit claims to, among other things: (1) ensure that claims and appeals determined by the plan administrators or other plan fiduciaries are adjudicated independently and impartially; (2) provide a full discussion of all reasons related to a claim denial; (3) require that claimants have access to their entire claim file and other relevant documents and have the right to present evidence supporting their claim during the review process; and (4) ensure that claimants are given the opportunity to seek court review if the plan failed to comply with the new claims procedure requirements (unless violation is due to minor error); and

WHEREAS, the Board desires to adopt the attached "Addendum to Plan Claims Procedure" (the "Addendum") in support of the claims procedures set forth in the Plans.

NOW, THEREFORE, BE IT RESOLVED, that the attached Addendum hereby supplements and amends the Claim Procedures set forth in the Plan to the extent that such procedures are implemented in the adjudication of a disability claim under the Plans and in the case of disability claims, the attached Addendum shall control; and

RESOLVED, FURTHER, the Bank or its designee shall be, and the same hereby is, authorized, empowered and directed to take any and all action necessary for the implementation of the aforesaid procedures.

SECRETARY'S CERTIFICATE

I, _____, Secretary of the [EMPLOYER] do hereby certify that the above resolutions were adopted by the Board of Directors at a meeting duly held on _____ ____, 2018.

_____
Secretary

Exhibit A

SAMPLE

<Date>

<Participant Name>
<Title>
<Address>
<City, State, Zip>

RE: New Claims Procedures for Employee Benefits Plans with Disability Benefits

Dear Participant:

This letter is to inform you of a change to a U.S. Department of Labor (DOL) regulation that will affect claims procedures for any plan that includes elective compensation deferrals or has disability as a vesting or payment event, where the determination of disability is made by the plan itself. In order to comply with the DOL rule, effective April 2, 2018, we are adopting the attached addendum to supplement the existing claims procedures for the plans set forth in Exhibit A attached hereto.

Generally speaking, the changes to the claims procedures are technical in nature and will not affect your benefits. We have been operating, and will continue to operate the plan, in compliance with the new regulations.

Sincerely,

<Company Representative or Plan Administrator Name>

Enclosures

Exhibit A