U.S. Department of Labor Office of Pension and Welfare Benefit Programs
Washington, D.C. 20210

MAY 8 1985

85-21A
Sec. 3(32), 4(b)(1)

Ms. Iris Altomare
33-52 Crescent Street
Long Island City
New York, New York 11106

Dear Ms. Altomare:

This is in reply to your letter of January 25, 1983, requesting an advisory opinion regarding applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether the UFT Welfare Fund Prescription Drug Plan (the Drug Plan) is an employee welfare benefit plan within the meaning of section 3(1) of ERISA and covered by title I of ERISA and the effect of certain provisions of ERISA.

You advise that the Drug Plan is one of a number of supplementary benefits offered through the UFT Welfare Fund (the Fund). The Fund was established by the United Federation of Teachers (UFT) and is administered by a Board of Trustees designated by the UFT. Under collective bargaining agreement with the UFT, the Board of Education of the City of New York (the Board of Education) agreed to contribute a designated amount on behalf of each of its employees covered by the Fund. It appears that there are no additional sources of contribution to the Drug Plan. It also appears that the only participants in the Fund are (1) employees (and possibly former employees) of the Board of Education who are covered by collective bargaining agreements with UFT and (2) dependents of covered employees. In addition to the Drug Plan, the Fund offers participating employees medical and hospital benefits, dental benefits, optical benefits, accident and disability benefits, and death benefits. These benefits supplement other benefits provided by the Board of Education to its employees.

You further advise that you are the beneficiary of a participant in the Drug Plan and that you have had a claim for benefits denied because it was submitted 94 days after the expense was incurred. The Drug Plan states that claims must be made within 90 days of the expense being incurred. You further state that your appeal of the claim denial was reviewed by the Board of Trustees of the Fund and again denied. Finally, you state that you have been notified that only a participant, and not a beneficiary, whose claim for benefits is denied is entitled to have the claim reviewed by the Board of Trustees of the Fund.

Based on the above, you ask the following:

> 1. Is the Drug Plan an employee welfare benefit plan within the meaning of section 3(1) of ERISA and covered by title I of ERISA or is it a governmental plan within the meaning of section 3(32) of ERISA and therefore exempt from coverage under title I?
> 2. May an ERISA-covered collectively bargained welfare plan make no provision for grievance and arbitration of denied plans?
> 3. May an ERISA-covered welfare plan not provide for initial determination of claims?
> 4. May an ERISA-covered welfare plan provide that only participants are entitled to claims procedures under ERISA if their claims are denied?
> 5. May an ERISA-covered welfare plan provide that, unless an otherwise valid claim is made within 90 days after the expense is incurred, the claim will not be honored?

Section 3(1) of ERISA defines the term "employee welfare benefit plan" to include:

> … any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

Section 4(b)(1) of ERISA provides that title I will not apply to any plan that is a governmental plan within the meaning of ERISA section 3(32). Section 3(32) defines the term "governmental plan" to include, in part, "... a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof or by any agency of instrumentality of any of the foregoing." The Department views the Drug Plan as being a "governmental plan" within the meaning of section 3(32) because only a governmental entity contributes to the Drug Plan on behalf of its employees and all employees covered are employees of that governmental entity.

The above constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of the procedure, including section 10 thereof relating to the effect of advisory opinions.

Although the Drug Plan is not covered by title I of ERISA in the Department's view, we have nevertheless formulated responses to the issues raised in the additional questions you submitted. They are explained here for your information for plans which are subject to title I of ERISA.

With regard to claims procedures, section 503 of title I of ERISA provides:

> Sec. 503. In accordance with regulations of the Secretary, every employee benefit plan shall-
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

In the Department's regulation 29 C.F.R. §2560.503-1 (copy enclosed) the Department provided minimum requirements for employee benefit plans subject to title I of ERISA pertaining to claims by participants and beneficiaries.

In connection with your second question, certain collectively bargained employee benefit plans subject to title I of ERISA may be deemed to comply with parts of the regulation if the collective bargaining agreement under which the plan is established or maintained provides or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject. However, the provision of such a procedure is not mandatory. See regulation section 2560.503-1(b)(2). If such a procedure is not provided, then the plan would have to otherwise comply with the regulation.

With regard to your third question, regulation section 2560.503-1(d) provides:

> (d) Filing of a claim for benefits. For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:
>
> (1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.
>
> (2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the

> joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.
> (3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more states, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.
> (4) For purposes of paragraphs (d)(1),(2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

However, regulation section 2560.503-1(b)(2) also provides that an employee benefit plan subject to title I of ERISA under certain circumstances may be deemed to meet regulation section 2560.503-1(d) if the collective bargaining agreement pursuant to which the plan is established or maintained provides or incorporates by specific reference, in addition to the grievance and arbitration procedure for denied claims, provisions concerning the filing of benefit claims and the initial disposition of benefit claims. In this regard, we note that a summary plan description ordinarily discusses how to obtain benefits under the plan.

With regard to your fourth question, regulation section 2560.503-1(g)(1) provides, in part, "Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim...." The term "claimant" is used in regulation section 2560.503-1(a) to refer to both participants and beneficiaries. It should be noted, however, that certain plans subject to title I of ERISA may be deemed to meet regulation section 2560.503-1(g) if they meet the criteria of section 2560.503-1(b)(2). We note, for example that appeals can be reviewed by a board of trustees and denied by them. Initial decisions on claims may be reviewed by a board of trustees and reconsidered by them on appeal.

Finally, with regard to your fifth question, regulation section 2560.503-1(b)(1) provides, in pertinent part:

> (i) A claims procedure will be deemed to be reasonable only if it: ...
> (ii) is described in the summary plan description, as required by §2520.102-3,
> (iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims....

I hope the above opinion and additional information will be helpful to you.

Sincerely,

Elliot I. Daniel
Acting Assistant Administrator for Regulations and Interpretations

Enclosures