Significant Disability Benefits Rulings From The Past Year

We asked attorneys who handle disability benefits cases to weigh in on why certain decisions handed down in the past year were significant.

Here are the decisions they picked and what they said about them. Each of the decisions pertains to a dispute that is governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq*.

Late Disability Claim Denial Forfeits Deferential Review

Cogdell v. Reliance Standard Life Ins. Co., 169 F.4th 238 (4th Cir. 2026)

Peter Sessions, Kantor & Kantor LLP, Northridge, Calif.: ERISA requires benefit plan administrators to give participants a "full and fair review" when they challenge the denials of their claims. 29 U.S.C. § 1133. The U.S. Department of Labor (DOL) has interpreted this to mean that if a disability plan administrator does not "strictly adhere" to regulatory claim deadlines, "the claim . . . is deemed denied on review without the exercise of discretion by an appropriate fiduciary." 29 C.F.R. § 2560.503-1(l)(2). In this case, a plan insurer argued that (1) its decision wasn't late because "special circumstances" allowed it to extend its deadline, and (2) even if it was late, it was still entitled to deferential review because of the plan's grant of discretionary authority.

In this published decision, the Fourth Circuit affirmed a district court ruling rejecting both arguments. The insurer contended that it needed more time to review the appeal and seek an independent medical report, but the court found that the insurer did not inform the claimant that its extension "was a special circumstance, nor did it explain how it could be one." The court noted that the plain meaning of the word "special" indicated something "out of the ordinary" or "unusual," and "a circumstance is not 'special' if it is commonplace in the appeals process." As a result, the insurer was not entitled to the extension and its decision was late.

Furthermore, the court ruled that the insurer's noncompliance stripped it of deferential review. The insurer advanced a substantial compliance argument, contending that it eventually decided the claim, even if it was late. The Fourth Circuit rejected this "No harm, no foul?" argument, explaining that "[d]ecisions made outside the boundaries of conferred discretion are not exercises of discretion[.]" The court approvingly cited a 2019 decision authored by then-Judge Amy Coney Barrett — Fessenden v. Reliance Standard Life Ins. Co., 927 F.3d 998 (7th Cir. 2019) — for the proposition that "the substantial compliance doctrine is incompatible with the applicable ERISA time restraints."

The insurer also argued that the Supreme Court's 2024 blockbuster decision Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024), supported the proposition that the DOL had no authority to create a regulation that revoked discretionary authority or determined the appropriate judicial standard of review. However, the Fourth Circuit stated that its standard of review did not flow from the regulation "but by [Supreme Court precedent] and the principles of trust law[.]" As a result, the insurer's decision was stripped of deference, and under more exacting *de novo* review, the Fourth Circuit agreed with the district court that the insurer erred in determining that the claimant was not disabled. Typically, ERISA's regulatory deadlines are invoked by administrators to turn back claims, but this case shows that turnabout is fair play; both sides must keep a watchful eye on the clock.

Long COVID Disability Claims And The Objective Evidence Requirement

Hans v. Unum Life Ins. Co. of Am., 817 F. Supp. 3d 238 (E.D. Pa. 2026)
Andrew I. Hamelsky, Stradley Ronon Stevens and Young LLP, Newark, N.J.: The judge in Hans offered an early practical roadmap for courts evaluating long COVID disability claims under deferential ERISA review. The decision recognizes an important distinction: An administrator may not deny benefits simply because long COVID lacks a definitive, objective diagnostic test, but it may require objective evidence that the condition produces functional limitations severe enough to satisfy the plan's disability standard. That distinction is likely to matter in future claims involving long COVID and other symptom-driven conditions where the diagnosis itself may be clinically accepted but the disputed issue is whether the claimant can perform the material duties of the relevant occupation.

The ruling also underscores how strongly plan language can shape the outcome of an "own occupation" dispute. Since the policy at issue defined "regular occupation" by how the job is normally performed in the national economy, the court upheld Unum's reliance on a lighter "ship pilot" classification rather than the claimant's more demanding real-world description of river-pilot work. For claimants and insurers alike, Hans is a reminder that long COVID cases will often turn less on whether the condition exists and more on the administrative record: the plan's occupational definition, the quality of functional evidence, the consistency of treating-provider restrictions and whether the administrator gives a reasoned explanation for crediting contrary medical and vocational reviews.

Meaningful Scrutiny Of ERISA Waivers

Schuyler v. Sun Life Assurance Co. of Can., 150 F.4th 57 (2d Cir. 2025)
Geannina Burgos, Dabdoub Law Firm, Coral Gables, Fla.: I view Schuyler as one of the critically important claimant-friendly ERISA decisions issued this year, not because of the underlying disability dispute, but because of what the Second Circuit had to say about waivers of ERISA rights.

For years, insurers have increasingly relied on separation agreements as a vehicle for cutting off benefit claims, often arguing that broad release language extends far beyond the employment-related disputes the claimant thought he or she was resolving. Schuyler pushes back against that trend.

What makes the decision significant is the court's insistence that ERISA waivers are different. The court recognized that the question is not simply whether release language can be read broadly enough to cover a claim. The real question is whether the claimant *knowingly and voluntarily* gave up an ERISA right. That distinction may seem subtle, but it is enormously important in practice.

The opinion is also significant because it focuses on the reality of how separation agreements are negotiated and understood. Disability claimants routinely seek clarification about the impact of a release on pending benefit claims. In many cases, they are told that the agreement will not affect their disability claim or appeal, only to face a waiver defense years later when litigation begins. The Second Circuit made clear that those communications matter. A claimant's actual understanding cannot be ignored simply because an insurer later points to expansive boilerplate language in a release.

From a plaintiff's perspective, this is an important reminder that courts are still willing to look at substance over form in appropriate cases. That is particularly important in the ERISA disability context, where insurers frequently seek dismissal based on technical defenses that have little to do with whether the claimant is actually entitled to benefits.

The decision is also likely to affect litigation strategy going forward. Insurers can be expected to continue raising release defenses, but Schuyler may make those defenses harder to win where the insurer was not a signatory to the agreement or was not specifically identified in the release or where preexecution communications created a different understanding regarding the claimant's benefit rights. Employers and insurers will likely respond by attempting to draft more explicit release provisions and more specifically addressing pending disability claims during separation negotiations.

Ultimately, Schuyler is significant because it reinforces a principle that sometimes gets lost in ERISA litigation: Courts should not lightly infer the surrender of valuable disability rights. The decision serves as a reminder that ERISA waivers remain subject to meaningful scrutiny and that a claimant's understanding of what was actually being released still matters. For claimants and their counsel, that is a very important development.

Preexisting Condition Exclusion In Disability Claim

Johnson v. Reliance Standard Life Ins. Co., 159 F.4th 1304 (11th Cir. 2025)
Jordan S. Kaplan, Robinson & Cole LLP, Boston: In Johnson, the 11th Circuit held that Reliance Standard Life Insurance Co. erred in denying long-term disability (LTD) benefits on the basis that a plan participant's scleroderma was an excluded preexisting condition. The disputed policy excluded preexisting conditions "for which" a participant received medical care in the three-month lookback period before coverage became effective. Despite receiving treatment for various symptoms, the participant was neither diagnosed with nor specifically treated for scleroderma until after the lookback period expired. Invoking the policy exclusion, the insurer denied the participant's LTD claim. The district court affirmed the insurer's decision as reasonable. The 11th Circuit disagreed.

The 11th Circuit reaffirmed its commitment to a unique "six-step sequence" for reviewing a plan administrator's ERISA benefits decision. Employing its distinct framework, the 11th Circuit first determined that the claim administrator's benefits-denial decision was "de novo wrong" (step one). Writing for a split panel, Judge Britt C. Grant explained that "for" was best read as signifying an intent to treat. Drawing on dictionary definitions and an opinion by then-Judge Samuel Alito, Judge Grant emphasized that doctors could not provide treatment "for" an ailment without being aware of what the condition was — or that it even existed. Because the participant could not receive medical treatment "for" a disease she was not yet diagnosed with, the panel determined that the insurer's interpretation was wrong.

Acknowledging that the policy expressly vested the insurer with discretion in reviewing claims (step two), the 11th Circuit next applied arbitrary and capricious review (step three). And although the arbitrary and capricious standard is deferential, the 11th Circuit demonstrated that it retains teeth, concluding that the insurer's interpretation was so wrong as to be unreasonable. The insurer's reading, Judge Grant explained, would all but transform "a preexisting condition exclusion into a preexisting-symptom exclusion" — directly contravening the policy's plain language. Having found no "reasonable" grounds for the insurer's decision, the 11th Circuit reversed and remanded, resolving the inquiry at step four of the court's ERISA benefits framework.

Chief Judge William H. Pryor Jr. dissented, arguing that the majority opinion incorrectly read an intent requirement into the policy exclusion. Instead, the phrase "for which" was properly read as synonymous with "because of." As the participant received medical treatment for symptoms later diagnosed as

scleroderma, the policy exclusion should apply — even if the doctors did not intentionally treat the participant for scleroderma.