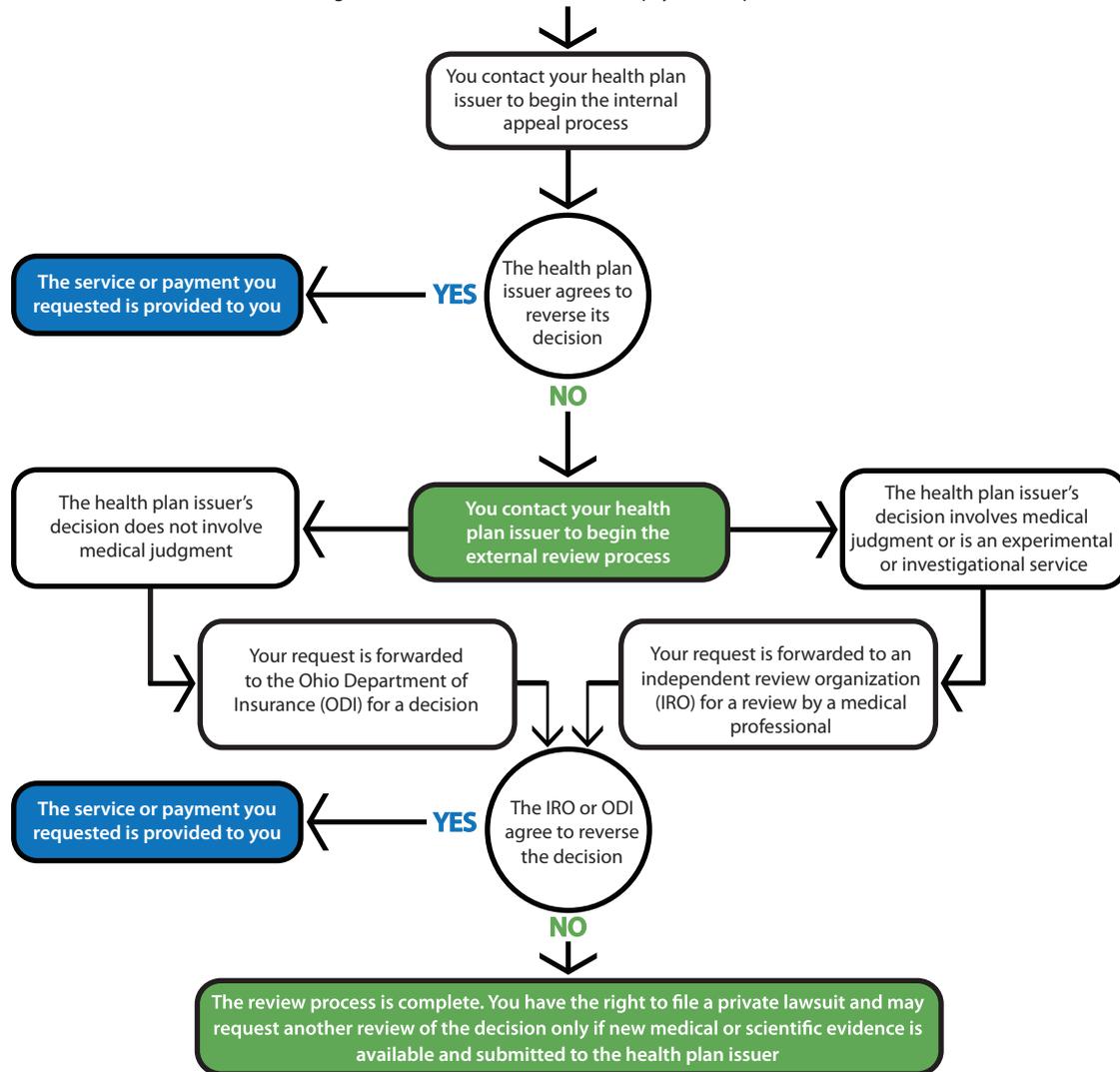


How to Appeal a Decision by Your Health Plan Issuer

If You disagree with a decision by your health plan issuer:

- To deny, or reduce, or terminate a health care service or payment in whole or in part;
- Not to issue health insurance coverage to you in the individual or non-employer group market; or,
- To cancel or discontinue your coverage under a health benefit plan back to the original effective date as if the coverage never existed other than for non-payment or premium or contribution. *Then...*



ODI
Ohio Department
of Insurance

We would like to thank the following associations for their assistance with this project:

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|---|--|
| Ohio Hospital Association | Ohio Academy of Family Physicians |
| Ohio State Chiropractic Association | Ohio Dental Association |
| Ohio Osteopathic Association | The Academy of Medicine of Cleveland and Northern Ohio |
| Ohio Podiatric Medical Association | Ohio Psychiatric Physicians Association |
| Ohio Psychiatric Association | |
| American College of Obstetricians and Gynecologists | |

With a special thanks to the Ohio State Medical Association

Questions?

Anyone with questions about the health coverage appeals process can call the department consumer hotline at:

1-800-686-1526

Ohio Department of Insurance
50 West Town Street - Suite 300
Columbus, OH 43215

www.ohioinsurance.gov

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How to Appeal a Health Coverage Decision Made by Your Insurer

Ohio law may allow consumers who have been previously denied coverage for a health insurance claim or have had coverage reduced or terminated the right to request an appeal of their insurer's decision.





Coverage Denial Eligible for Appeal

The law applies to most health insurance plans, including HMOs and PPOs, and most public employee benefit plans. It does not apply to members of private self-insured plans. Check with your company's employee benefits administrator or insurance agent to learn if your coverage qualifies for the appeal process.

First: Appeal to the Insurance Company

The plan's internal appeal process is your first step if you disagree with a decision your insurance company makes. Review your policy or benefits booklet for information on filing a complaint and/or an appeal. You can also contact the company's customer service office. Most companies have toll-free hotline numbers. After a review, the company will send you a letter explaining why the appeal has been reversed or denied and outline your next steps.

Second: Contact the Ohio Department of Insurance's Office of Consumer Affairs

If you have been told by your insurer that the service you requested is not covered under your policy and is not a question of medical necessity, you can contact the Ohio Department of Insurance's Office of Consumer Affairs to initiate another appeal of this decision. The Department will review the matter, working with both the consumer and the insurance company to achieve resolution. A review generally takes 30 days but each case is different. For more information, contact the Department at our toll-free hotline, 1-800-686-1526, or on the web at www.ohioinsurance.gov. Consumers do not bear the cost of this review.

Third: Request an External Review

If the plan denies, reduces or terminates a service or treatment because the plan determines it is not a medical necessity, experimental or investigational, your case could be eligible for an external review with an independent review organization (IRO). Physician experts knowledgeable on the specific medical condition are employed by IRO's to review the case. You must initiate an external review by contacting your insurance company.

Appeals denied through a health plan's internal process generally may qualify for external review with an IRO when:

- The insurance company has determined the service you want is not medically necessary.
- Your provider documents that the service (and all care related to the service) will cost you more than \$500 if not covered.
- You request external review within 60 days of being notified about the internal decision.

The IRO must make its decision within 30 days. Decisions must be expedited within seven days if your health condition requires it. Decisions by the IRO in favor of the consumer are binding on the insurer, while consumers retain the right to file private lawsuits even if the IRO decision is not in their favor. Consumers do not bear the cost of the IRO review.

Physician's Role

A physician can appeal the insurer's decision on behalf of the patient only with the patient's consent. If you decide to file an appeal, the physician is required to provide the patient with any necessary supporting documentation. In the case of a non-terminal condition or a non-expedited review, the physician must certify that the procedure, technology or service, including follow-up care, would be at least \$500. In the case of an expedited review, the physician must identify the patient's needs and certify the patient's health could be in serious jeopardy. In the case of a terminal condition, the physician must certify death is likely within two years and more help is needed than standard therapy.

