How it Works: The Internal Appeal Process

The federal health care reform law, known as the Affordable Care Act (ACA), ensures you have certain rights if your health insurer denies your claim. These rights make the process of appealing the insurer's decision more transparent, accountable, and fair.

There are two stages of appeals you can choose to pursue if your claim is denied: an internal appeal and an external review. In most cases, you must request an internal appeal before you can request an external review.

What is an internal appeal?

In an internal appeal, also known as a grievance procedure, an insurer reviews its decision to deny coverage for your claim. The ACA requires insurers to adhere to a strict timeline and provide detailed and complete information to you for free about their reason for denying your claim.

If at any point your insurer does not fulfill its obligations in the internal appeals process, you may immediately file an external appeal.

While your internal appeal is pending, your insurer can not reduce or stop coverage for ongoing treatment.

When do I file an internal appeal?

Once you receive notification from your insurer of their decision to deny your claim, you have **180 days** to file an internal appeal. Your insurer must provide notice of a decision to deny your claim within:

- 72 hours for an urgent care claim, as determined by your doctor;
- 30 days for a non-urgent care claim submitted before the service is provided;
- 60 days for a non-urgent care claim submitted after the service is provided; and
- 24 hours for ongoing treatment that the insurer has approved, but is seeking to reduce or stop.

Your internal appeal rights

A full and fair review of your claim's denial is required under the ACA. Your insurer must take steps to preserve the impartiality of decision makers in your appeal.

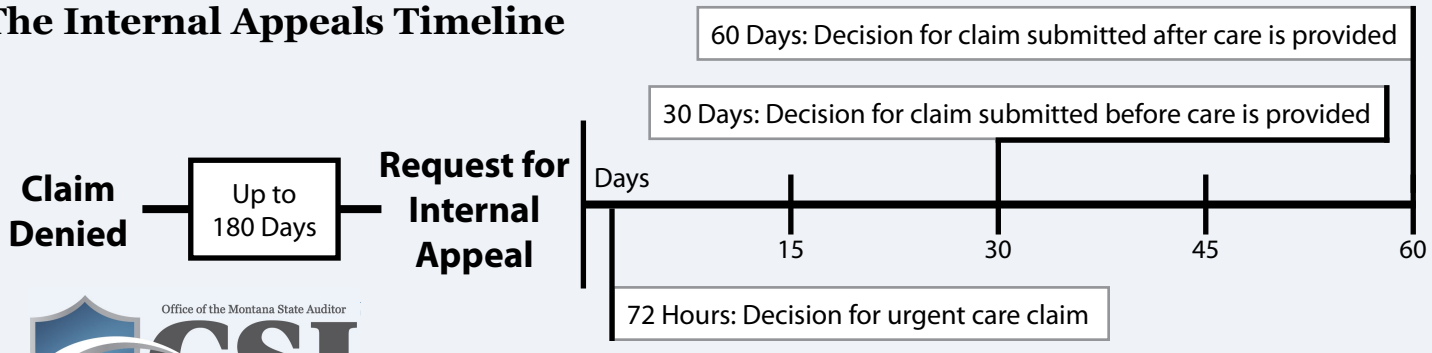
In all internal appeals, your insurer must provide to you free of charge:

- An opportunity to review your claim file and to present evidence or testimony on your behalf;
- Any new or additional evidence considered in your claim before they issue a final decision; and
- A reasonable opportunity to respond to any new information before they issue a final decision.

Once your insurer makes a final decision on your internal appeal, your insurer must provide notice to you that includes:

- Their decision and the rationale behind it;
- Notice of your right to seek external review, including instructions and time limits for filing an appeal; and
- Contact information for the Commissioner of Insurance. The Commissioner can assist you with filing your appeal.

The Internal Appeals Timeline



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Insurance Benefit System Administrators I Attn: Internal Claim Reviews I PO Box 2917 I Shawnee Mission, KS 66201-1317

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How it Works: The External Review Process

The federal health care reform law, known as the Affordable Care Act (ACA), ensures you have certain rights if your health insurer denies your claim. These rights make the process of appealing the insurer's decision more transparent, accountable, and fair.

After the internal appeal process has been exhausted, you may request an external review of your insurer's decision to deny your claim. In some cases, the internal appeal does not need to be exhausted.

What is an external review?

An external review is an independent medical review of an insurers' decision that a health care service is experimental, investigational, or not medically necessary. An insurer's decision to rescind your policy is also subject to external review. Medical professionals from an **independent review organization (IRO)** with no connection to the health plan must conduct the review.

The new rules for external review provided by the ACA and outlined in this document **do not apply** to grandfathered health plans. Generally, plans issued before March 23, 2010, are grandfathered, unless certain benefit changes trigger a loss of grandfathered status. Check with your insurer to see if your plan is grandfathered.

When do I file an external review?

You have **4 months** to file for an external review after you receive notice from your insurer that your internal appeal has been denied.

Once your insurer has received your external review request, they have 5 business days to determine whether or not your claim is eligible for external review.

Your insurer has 1 business day after completing this preliminary review to notify you of the results.

If your claim is eligible, your insurer must provide information from your request and their decision within 5 business days to one of three contracted IROs assigned randomly. Failure to provide complete information before this deadline will result in the IRO ruling in your favor and reversing the claim denial.

You may submit additional information to the assigned IRO within 10 business days. The IRO may accept additional information from you beyond this 10 day period. The IRO must send any additional information to the insurer within 1 day.

The IRO must make its final decision within 45 days of receiving the request from your insurer.

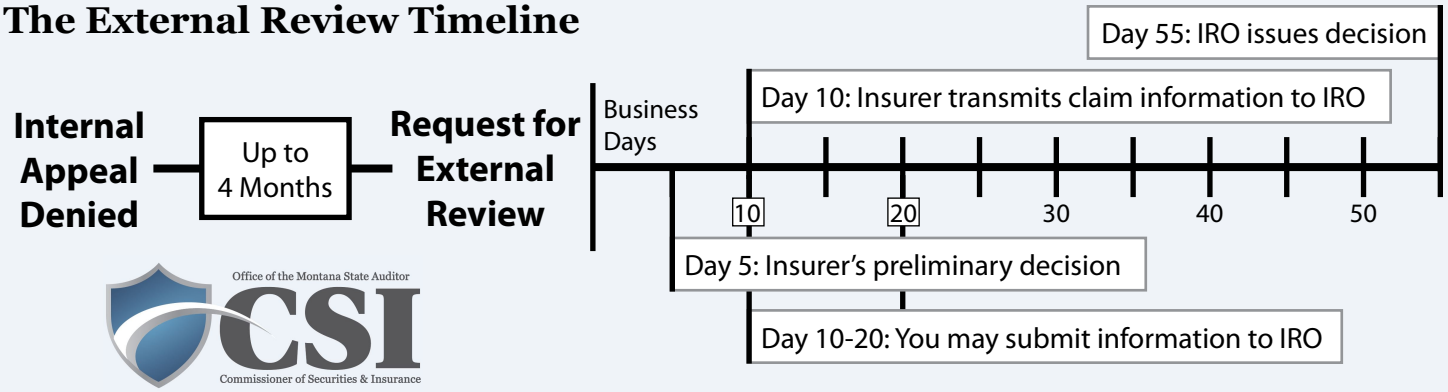
Expedited external reviews are available in cases of urgent medical care, as determined by your doctor. In urgent cases, your insurer must notify you immediately of their decision to deny your internal appeal, then immediately assign an IRO to your claim and transmit all necessary information to the IRO. The IRO must issue its decision within 72 hours.

Your external review rights

The ACA paved the way for new rules to ensure the IRO charged with reviewing your claim is truly independent. Those rules require that:

- IROs must not receive financial incentives based on the outcome of your claim;
- IROs must have legal experts on staff, in addition to the medical experts reviewing your claim; and
- IROs must conduct a full review of your claim from the beginning without regard for the result of an internal appeal.

The External Review Timeline



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