Your insurance appeal has been **DENIED**.

For free help, if you don’t understand this document or want help appealing further, contact the State Healthcare Advocate:

(866) 466-4446 or [Healthcare.Advocate@ct.gov](mailto:Healthcare.Advocate@ct.gov)

##### Additional information regarding your rights is available in the section of this notice labeled CT Consumer Healthcare Advocacy/Department of Insurance Information.

<LOGO>

«DATE»

Connecticut Template for Fully Insured Plan

Recipient Name

{{address}}

{{city}}, ST 00000

**Initial Notice of Adverse Determination (Fully Insured)**

Date of Notice: Today’s Date

Name of Plan: Plan Name

Group: Group Name

{{address}}:

Telephone/Fax: Plan Phone/Fax Number

Website: Plan Website

|  |  |
| --- | --- |
| **Patient Name:** Patient’s Name | **ID Number:** Member Number |
| **Address:** Member Address | |
| **Reference #: Auth/Reference** Number | **Date(s) of Service:** Date(s) of Service. |
| **Provider:** | **Facility:** |
| **In-Network:** <Yes/No> | **Out-of-Network:** <Yes/No> |
| **Description of Service:** Description of service | **Codes:** Denial reason |

**This document contains important information that you should retain for your records.**

|  |
| --- |
| The Health Care Management Department (HCM) at Luminare Health Benefits, Inc., is the utilization review entity working with Delaware American Life Insurance Company to review health benefits for medical necessity.  A board-certified M.D./D.O. specializing in [list specialization] has reviewed the medical information that was provided as part of your health care service(s) request. Their review determined the service(s) has not met the definition of medically necessary according to the rules established by your benefit plan.  We hope this information will help you understand our determination. We regret we are unable to provide a more favorable response, but please be assured your request has been carefully reviewed.  You are getting this notice because your request for service(s) was [partially] denied. Why did we decide to [partially] deny the request?HCM on behalf of Delaware American Life Insurance Company [denied] or [partially approve] this [service] because the *{insert reason as applicable\*}* [service is not medically necessary]  [service is experimental/investigational]  [a custodial level of care]  [request for clinical information to support the utilization review process was not provided]  [Physician Specialist has had a Peer-to-Peer conversation with the attending Physician and the decision was upheld]  [Physician Specialist was unable to reach the attending Physician for a Peer-to-Peer conversation] |

To approve this service the following criteria must be met: [Insert criteria required for the service to be approved].

Example 1: MCG Health Ambulatory Care 25th Edition: Abdominal/Pelvic CT Scan ACG: A-0013 (AC)

Example 2: MCG Health Ambulatory Care 25th Edition: Brain MRI ACG: A-0047 (AC)

Example 3: MCG Health Ambulatory Care 25th Edition: Chest CT Scan ACG: A-0028 (AC)

These criteria are not met because [Insert specific Physician Review IRO summary OR specific Plan criteria not met]

Example: Your health plan follows set guidelines for correct use of your medical benefits. Your doctor ordered CT (computerized tomography) of your chest, CT abdomen/pelvis and Brain MRI (magnetic resonance imaging). You do not meet guidelines for these tests. These tests were not medically necessary based on the policies provided.

**The following link may be used to access clinical criteria used in making this determination:**

**<https://www.luminarehealth.com/what-we-do/products-and-solutions/healthcare-management-resources-mcg-noindex> <Insert any additional information (i.e.: password, etc.) that member may require to access clinical information>**

**[REMOVE IF NOT PERTINENT PLAN LANGUAGE]** The Plan rule/s on which this decision is based may be found in the (**Insert** the section title) section of your health plan document on page (**Insert** page #). *<***Include** a discussion of this provision as it relates to the covered person’s specific situation.>

**Offer of Language Assistance**

SPANISH (Español): Para obtener asistencia en Español, llame al insert phone # for Spanish line.

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa insert phone # for Tagalog line.  
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码insert phone # for Chinese line。

NAVAJO (Dine): Dinek'ehgo shika at’ohwol ninisingo, kwiijigo holne' insert phone # for Navajo line.

**Important Information about Your Appeal Rights**

**What if I need help understanding this adverse notice?** Please contact the Healthcare Management Department at 1-800-480-6658, ext. 15605, from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday during normal business hours or fax to 1-888-708-0854.

**What if I don’t agree with this decision?** You have a right to appeal any adverse decision.

**How do I file an appeal?** Appeal requests can be made in writing or by telephone. Member appeals must be received within **180 days** from the date of this notice.

You may **telephone** us with your urgent or non-urgent appeal request, at 800-480-6658, ext. 15605 from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday.

You may **mail** your **non-urgent** appeal request to:

Healthcare Management Department

Attn: Physician Review Coordinator, Appeals

1280 N. Plum Street

Lancaster Pennsylvania, 17601

**Please be advised**that postal service deliveries are monitored only during regular business hours, 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday.

**You may FAX your non-urgent appeal request** to 717-295-1208, from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday. **Please be advised**that FAX transmissions are monitored only during these regular business hours.

Complete the bottom of this page, make a copy, and send this document to below address or FAX to the number above. HCM will respond to your non-urgent appeal request within fifteen (15) calendar days of receipt of the necessary information. If your appeal is for a retrospective appeal, HCM will respond to your request within thirty (30) days of receipt of the necessary information.

See also the “Other resources to help you” section of this form for assistance filing a request for an appeal.

Health Care Management

Attn: Physician Review Coordinator Appeals

1280 N. Plum Street

Lancaster Pennsylvania, 17601

**What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will be conducted **within 72 hours**. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your physician, you may experience severe pain that cannot be adequately controlled without immediate treatment. If you believe your situation is urgent, you may request an expedited appeal by calling 800-480-6658, ext. 15605 from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday. You can also a request for simultaneous external review by mailing the attached form on the to the following address: <Insert claims address that corresponds with applicable claims platform.>

**Who may file an appeal?** You or someone you name and agree in writing to act for you (your authorized representative) may file an appeal.

**Can I provide additional information about my case?** Yes, you may supply additional information in support of your case to the following address or FAX to 717-295-1208:

Health Care Management

Attn: Physician Review Coordinator

1280 N. Plum Street,

Lancaster, Pennsylvania 17601

**Can I request copies of information relevant to my case?** Yes, you may request copies (free of charge). If you think a coding error may have caused this case to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at 800-480-6658, ext. 15605 from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday.

**What happens next?** If you appeal, we will review the decision and provide you with a written determination. If we uphold the original decision of the requested service, or you do not receive a timely decision, you may be able to request an external review of medical necessity by an independent third party, who will review the determination and issue a final decision. External review applies to an adverse benefit determination involving medical judgment, including, but not limited to, those plan requirements involving medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or experimental or investigational treatments or services.

**You may be immediately entitled to an expedited independent expedited external review prior to completing any further internal Healthcare Management appeals, if:**

* You or your authorized representative, may file and expedited external review at the same time a request for an expedited internal review of this denial, except that the independent review organization assigned to conduct the expedited external review will determine whether the member shall be required to complete the expedited internal review of the prior to conducting the expedited external review.
* You, or your physician, feel that an external review request needs to be urgently processed due to emergency or life-threatening circumstances
* You, or your physician, feel that an external review request needs to be urgently processed because a delay would seriously jeopardize the effectiveness of a therapeutic service, your ability to fully recover, or your ability to adequately manage your pain
* You have received a final adverse determination letter concerning healthcare services for which you received emergency care and you have not yet been discharged from the treating facility
* You, or your physician, feel that an external review request needs to be urgently processed because a delay in treatment would seriously jeopardize the effectiveness of a therapy that has been identified as “experimental or investigational”

**Other resources to help you:** For questions about your rights, this notice, or for assistance, you can contact:

The Employee Benefits Security Administration at 1-866-444-EBSA (3272)

Additionally, a consumer assistance program can help you file your appeal:

**You have the right to contact the commissioner’s office or the office of the Healthcare Advocate any time for assistance or, upon the completion of the internal grievance process, to file a civil action in a court of competent jurisdiction.**

**Connecticut Insurance Commissioner**

For assistance, or if you feel that you have been given incorrect information about your case, you may contact the Connecticut Insurance Commissioner, at:

{{stateCode}} of Connecticut Insurance Department Consumer Affairs Unit

PO Box 816

Hartford, CT 06142-0816

Tel: 860-297-3900 or 800-203-3447

Email: [cid.ca@ct.gov](mailto:cid.ca@ct.gov)

**Connecticut Office of the Healthcare Advocate**

For assistance, or if you feel that you have been given incorrect information about your case, you may also contact the Connecticut Office of the Healthcare Advocate, at:

{{stateCode}} of Connecticut Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06144

Tel: 866-466-4446

Fax: 860-297-3992

[www.ct.gov/oha](http://www.ct.gov/oha)

Email: [Healthcare.advocate@ct.gov](mailto:Healthcare.advocate@ct.gov)

**Formal Grievance Review:** You, your medical provider, or your authorized representative may submit a written request for a Formal Grievance Review, if you have a complaint about any of the following:

* Insurance Company decisions, policies, or actions related to coverage of health care services;
* Claims payment or handling;
* The contractual relationship between a Covered Person and the Insurance Company;
* The outcome of an appeal on a denial of certification of an admission or service or continued stay or treatment.

**How to submit your request for Formal Grievance Review:** You may submit your request for Formal Grievance Review within 180 days of receiving the decision or information about which you have a complaint, either by telephone 1-866-217-5631 or in writing. If we receive your request for a Formal Grievance Review, we will send you a form to use to complete the request in writing. Your written request should contain the issues and comments which are pertinent and should be sent or faxed to:

**Luminare Health Benefits, Inc., Healthcare Management Department**

**Attn: Physician Review Coordinator**

**Grievance and Appeals**

**PO Box 83301**

**Lancaster PA 17608-3301**

**Fax (717) 295-1208**

If the subject of your grievance relates to medical or clinical matters, including medical necessity and appropriateness of treatment, we will assign licensed, certified, or registered health care personnel with expertise in the corresponding field to conduct the review. The review will be conducted by personnel other than those who took the initial adverse decision.

**Formal Grievance Review resolution:** We will, within 5 business days after receiving your Formal Grievance Review request, send a notification of the investigation process. The notice will include the name, address, and telephone number of the individual or department designated to respond to the grievance. For requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract, a written decision will be made within 30 calendar days after receipt of all necessary information. Urgent (Expedited) will be completed: (i) Within twenty-four

(24) hours of receipt of a request related to the diagnosis of Mental Disorder or Substance Use Disorder (or co-occurring Mental Disorder); (ii) Within forty-eight (48) hours of receipt of all other requests or seventy-two (72) hours if any portion of the forty-eight (48) hour period falls on a weekend.

You will be provided with written notice of the disposition of your grievance within 5 days after it is decided.

If we deny your claim for medical services at the Formal Grievance Review level, we will advise you that our decision is a Final Adverse Decision and advise you of your right to request an External Review or right to contact the Connecticut Insurance Department to provide the information and forms necessary to file a request for an External Review.

If you or your authorized representative chooses to file a grievance of an adverse determination:

1. Such appeals are sometimes successful
2. You or your authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time.
3. You or your authorized representative is entitled and encouraged to submit supporting documentation for Luminare Health Benefits consideration during the review of an adverse determination, including narratives from you or your authorized representative and letters and treatment notes from your health care professional, and
4. You or your authorized representative has the right to ask your health care professional for such letters or treatment notes

**Appeal Filing Form**

**NAME OF PERSON FILING APPEAL:**

**Circle relation to patient:** Covered person Patient Guardian Authorized Representative

**Contact information of person filing appeal (if different from patient)**

{{address}}: Daytime phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:**

**If person filing appeal is other than patient, patient must indicate authorization by signing here:**

**Patient/Guardian or Representative Signature:**  \_\_\_\_\_\_\_\_\_\_\_\_

**Briefly describe why you disagree with this decision** (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim)**:**

Send this form and your denial notice to:

**Luminare Health Benefits, Inc., Healthcare Management Department**

**Attn: Physician Review Coordinator**

**Grievance and Appeals**

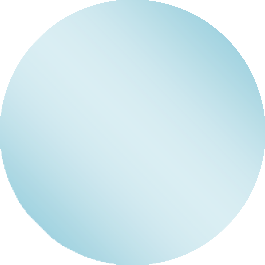
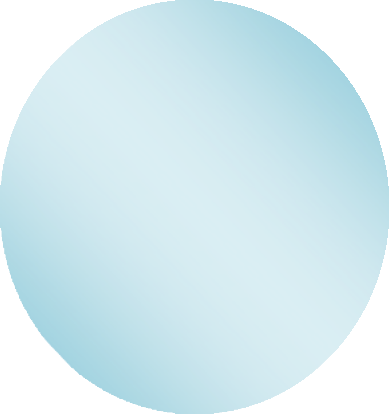
**PO Box 83301**

**Lancaster PA 17608-3301**

**Fax (717) 295-1208**

**Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.**

*[Using the specific plan language for bringing legal action, include the timeframe to bring such action. In the National Plan document this is found under General Provisions. For West standard plan documents, this wording is found in General Information. For Central standard plan documents, this wording is found in the Appeals section. Then remove this section in italics. Example sentence using language from National Plan document-* All claim review procedures provided for in your Plan Document must be exhausted before any legal or equitable action is brought.Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the Plan, plan administrator/claims processor, any other fiduciary, or their employees, must be filed within two (2) years from the date the expense was incurred or one (1) year from the date the completed claim was filed, whichever occurred first. *]*



{{stateCode}} of Connecticut Insurance Department External Review Program

# Frequently Asked Questions about Appeals, External Review, and Independent Review Organizations (IRO)

**August 2022**

### Introduction

This guide is designed to assist consumers who have been denied coverage for a treatment or service under their health insurance plan.

This overview provides information on the appeal process through the insurance company, as well as information on filing for an independent review through the {{stateCode}} of Connecticut External Review Program.

### Why was my request denied?

When you receive a denial notice, your insurance company is required to disclose to you the reason for the denial. These reasons might include:

* Services are considered not “medically necessary”
* Services are no longer needed in that health care setting or level of care
* The effectiveness of the health care services has not been proven
* Services are considered experimental or investigational for treatment of this condition
* Exception for out-of-network provider is not needed as adequate providers are available within the network

It is important to understand the reason why your request for services has been denied by your insurance company. This will enable you to work with your doctor to obtain medical documentation to support your need for these services.

### What are my rights as a consumer if I am denied services?

If you receive a denial based on one of the reasons above, you have the right to appeal this decision to your insurance company for another review.

If you are unsuccessful, you have the additional right to have this decision reviewed by an Independent Review Organization through the {{stateCode}} of Connecticut External Review Program.

### How do I appeal this denial with my insurance company (Internal Appeal)?

If your insurance company denies your request for authorization of services, they must also inform you of your right to appeal this decision.

If you disagree with the decision of the insurance company, you have 180 days to file an appeal of this decision. Each denial letter from an insurance company will give you very specific information on how to file an appeal and where this request should be sent.

If you choose to file an appeal, it is important that you follow the appeals instructions printed in the denial letter and act within the designated timeframes. If you don’t file your appeal within these timeframes, you lose your rights to further review of the decision.

### What information is my insurance company required to provide?

To assist you in your appeal, you are entitled to request from your insurance company “free of charge” reasonable access to, and copies of all documents, records, and other information relevant to your request for services. Information on how to request this information is printed in your denial letter.

### What information should I include when filing an appeal with my insurance company?

It is important that you include any materials that might support your need for the services in question, including any new supporting documents. You may also ask your treating physician to provide information that would be helpful to your appeal.

### Important documents to submit with your appeal might include:

* A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
* Treatment notes from your treating physician that provide information on the medical care provided to you
* The results of any relevant tests or procedures related to the requested service
* Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
* For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

### Whom may I contact for free assistance in preparing my appeal?

You have the right to free assistance in filing your appeal with the following state organization:

##### Office of the Healthcare Advocate

P.O. Box 1543

Hartford CT 06144

Telephone: 866-466-4446

Email: [Healthcare.advocate@ct.gov](mailto:Healthcare.advocate@ct.gov)

Website: [www.ct.gov/oha](http://www.ct.gov/oha)

### What should I do if my appeal for services is of an urgent nature?

All insurance companies are required to have a process in place for expedited handling of appeals for urgent care requests.

Urgent care appeals are available in any of the following situations:

* Standard timeframes for processing of a standard appeal would seriously jeopardize your life or health or your ability to regain maximum function
* Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services
* Your request is for services related to a behavioral health or substance abuse disorder

**Urgent Care Review of Specified Behavioral Health Services**

If you are seeking services related to a substance abuse disorder or co-occurring mental disorder, your request will automatically be handled as an urgent care appeal. For services related to a behavioral health disorder, your request will be considered urgent for the following services:

* Inpatient Services
* Partial Hospitalization
* Residential Treatment
* Intensive Outpatient Service necessary to avoid an inpatient setting

Please Note: Urgent care appeals are not available when services have already been received.

### Who reviews my appeal at the insurance company?

Your insurance company is required to select a clinical reviewer who is a physician or health care professional in the same or similar specialty as typically manages your medical condition, procedure, or treatment. For behavioral health or substance abuse services, a reviewer with a specified board certification in a specialty relevant to the requested services is required.

### If my request is still denied and I have exhausted all my appeals with the insurance company, what are my rights to External Review?

Once you have exhausted all the mandatory internal appeals with your insurance company, you may file for an External Review. For urgent care requests, you may submit for an External Review immediately after any insurance company denial.

### How do I know if I qualify for an External Review?

To be eligible for Connecticut’s External Review Program you must meet the following criteria:

#### You must have exhausted the internal appeal requirements of your plan.

Your letter from the company will state that this is the “final determination”. This is waived for urgent care requests.

#### The denial reason must qualify for an External Review.

If the denial reason in your final

determination letter is related to medical necessary, an experimental/investigational review, eligibility, rescission of coverage, or an in-network exception; then your denial qualifies for consideration under the External Review Program.

#### The services you request must be covered under your plan.

Requests for External Review must be for services that are provided under your insurance plan.

Contractual denials for non-covered benefits are not eligible.

#### You must file your complete External Review request within 120 days of the final determination letter.

It is important to file within the timeframes so that you retain your right to further review of this denial.

#### Your coverage must be provided by a fully insured plan issued in the {{stateCode}} of Connecticut or you must be covered through the {{stateCode}} of Connecticut employee plan.

Self-insured plans are not included in the Connecticut External Review Program. (See the glossary for a description of self-insured plans.) Your claims administrator can tell you if your plan is

“self-insured” and if so, direct you to External Review options available to you under your plan.

### How can I qualify for an expedited External Review?

The External Review Program provides for expedited handling of urgent care External Review requests. This is not available if services have already been received.

Expedited External Review requests are conducted when your provider certifies that:

* + Standard timeframes for processing of a standard External Review would seriously jeopardize your life or health or your ability to regain maximum function; or
  + Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services.

If you are seeking services related to a substance abuse or behavioral health disorder, your request will automatically be handled as an expedited External Review.

### What do I need to submit to request an External Review?

The External Review application has “Submission Instructions” to ensure that you submit all items that are necessary for acceptance of your request.

Required items to initiate an External Review are:

* + Completed and signed External Review Application
  + Copy of your medical insurance ID card
  + Copy of the final denial letter from your insurance company. For expedited reviews, attach the last denial letter received.

For expedited requests only:

* + Signed Physician Certification Form

- *(waived for behavioral health or substance abuse denials)*

### What medical information should I submit with my External Review?

Providing complete medical documentation gives you the best opportunity to have a thorough and comprehensive review of your request for services.

Your health plan will automatically transfer your appeals file to the independent review organization for inclusion in their External Review.

You should also be aware that you may ask your treating physician to provide any new information that would be helpful to your External Review.

Relevant information might include:

* + A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
  + Treatment notes from your treating physician that provide information on the medical care provided to you to date
  + The results of any relevant tests or procedures related to the requested service
  + Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
  + For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

### Who will review my External Review?

The Connecticut Insurance Department contracts with independent review organizations (IRO). Your External Review will be assigned to one of these contracted IROs.

IROs are independent organizations with no affiliation with your insurance company. This ensures that you receive an impartial review.

IROs are required to assign an individual clinical reviewer to your External Review who holds a license in the same or similar specialty as typically manages the medical condition under review. For appeals of behavioral health or substance abuse services, IROs are required to have a reviewer with a specified board certification in a specialty relevant to the requested services.

The clinical reviewer will review the following information:

* + Any documents or information that your health plan used in making their determination
  + Submitted medical records
  + Consulting reports submitted by appropriate health care professionals
  + Current practice guidelines and evidence- based standards for treatment of your condition
  + Clinical review criteria used by your health plan
  + Any other material submitted in support of your appeal

For medical necessity denials, the IRO will conduct a review and make a determination on whether the services are medically necessary and should be approved. For reviews involving eligibility, an

in-network exception or rescission of coverage; the IRO will decide whether the insurance company’s decision should be reversed.

The decision of the IRO is independent of the insurance company and the {{stateCode}} of Connecticut Insurance Department.

### How soon can I expect the decision on my External Review?

Based on the type of External Review request, the IRO will notify you of their decision within the timeframes as shown below.

**Timeframes for External Review Decisions**

* Standard – 45 Days
* Experimental/Investigational – 20 Days Expedited External Reviews
* Behavioral Health or Substance Abuse – 24 Hours
* Experimental/Investigational – 5 Days
* All Other Expedited Requests – 48 Hours\*

\*72 hours if the 48-hour time-period falls on a weekend.

### How will I be notified of the IRO’s External Review decision?

You will be notified directly by the IRO of their decision and a copy will also be shared with the Insurance Department, the insurance company, and the treating physician listed in your application.

The IRO will make one of the following decisions:

* + **Uphold** – confirms the denial
  + **Reverse** – overturns the denial
  + **Revise** - partially overturns the denial

If the IRO finds in your favor, then the insurance company is required to approve the services that were previously denied. All claims will be processed in accordance with the terms and conditions of your plan. All decisions of the IRO are final, and the decision is binding. There is no provision under state statute for any party to further appeal an IRO’s External Review decision.

### How often are External Review requests decided in favor of the consumer?

The External Review Program has been successful in helping consumers receive an independent and impartial review of their health insurance denials. It is important to note that historically nearly 40% of all denials are overturned through the program.

### Where should I send my External Review request?

##### Please send your External Review to:

Connecticut Insurance Department Attn: External Review

P.O. Box 816

Hartford CT 06142-0816 Email: [insurance@ct.gov](mailto:insurance@ct.gov)

### What if I have further questions on the External Review process?

For information or an External Review Application:

**Connecticut Insurance Department** Consumer Affairs Division Telephone: 860-297-3910

Email: [insurance@ct.gov](mailto:insurance@ct.gov) Website: [www.ct.gov/cid](http://www.ct.gov/cid)

For free assistance in preparing your appeal:

##### Office of the Healthcare Advocate

Telephone: 866-466-4446

Email: [Healthcare.advocate@ct.gov](mailto:Healthcare.advocate@ct.gov) Website: [www.ct.gov/oha](http://www.ct.gov/oha)

# Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but it isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.

## Medically Necessary

**Appeal (Internal)**

A request for your health insurance company to review a decision that denies a benefit or payment.

**Authorized Representative**

Someone who you choose to act on your behalf, like a family member or other trusted person. Authorized representatives must have your signed consent on the External Review Application to exercise your rights to an External Review.

**Benefits**

The health care items, or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

**Network**

Facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

## Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

## Claim

**Self-Insured Plan**

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract for insurance services with a third-party administrator.

A request for payment for items or services that you or your health care provider submits to your health insurer.

**External Review**

A process where individuals may request an independent third-party review of a health plan's denial of a treatment or service under their plan.

An External Review either upholds the plan's decision or overturns all or some of the plan’s decision. The health plan must accept this determination.