NOT A COVERED BENEFIT

Introduction:
Both private and public health insurance plans can deny coverage for a service on the grounds that it is "not a covered benefit." This type of denial means that, according to your health insurance plan, your member benefits do not include the requested service and you are responsible to pay for the service.

What are my rights when my plan denies a service as "not a covered benefit?"
You have the right to appeal. There are specific deadlines to appeal. If you do not appeal your plan's denial within the specified timeframe, you may lose your right to appeal.[1]

How do I prepare my appeal?
First, read all pages of your written denial that outlines your right to appeal. It should also include instructions on how to appeal, and the deadlines for doing so. Most plans have two levels of appeals.

You have a right to get details of why your plan refused to pay for your care. Your plan must provide you with free copies of your case record, the medical evidence the plan used to make its decision, and the plan's guidelines about why it doesn't cover the requested service.[2] Your plan must provide you with this information for free. Complain to the New York State Department of Financial Services if you cannot get this information from the plan.

You have a right to present any testimony or evidence for the health plan to consider when reviewing your internal appeal. In your appeal, you should respond to any evidence your health plan uses in their denial. For example, you can submit letters from your doctors, a statement of your own or a copy of your benefit contract, etc., explaining why the requested service *is* covered under your benefits.

Argue that the requested service falls into a category of covered services under your member benefits. If your plan is saying that the service is explicitly excluded under your benefits, your appeal should explain why the service does not fall under the category of excluded services. For example, if they are claiming that your surgery is cosmetic, and therefore not a covered benefit, your appeal should make the argument that your surgery does not meet the plan's definition of cosmetic. Lastly, if the requested service is a covered benefit in some circumstances but not in others, your appeal should explain why the service should be covered in your particular case.

Conclusion
Submit your appeal to your health plan! Keep a copy of anything you send to the plan and write down the date you sent it. When you speak with insurance representatives regarding your appeal, take detailed notes of your phone conversations (e.g., dates, names, and call reference numbers).

**** When your plan finishes its review of your internal appeal, it must provide you with a written decision and the reasons for it. The decision must also explain your additional appeal rights. ****

If you have any more questions or need further assistance appealing your health plan's decision, please call our Helpline at 888-614-5400. Be sure to mention that you've called before so that we can see all the information we have about your case.

[1] The appeal deadlines are listed on your denial or Explanation of Benefits. Appeal information, including timing requirements, can also be found in the member's benefits summary package. If you do not have your benefits summary package, call your health insurance company and request a new package. Your benefits summary package may also be available online.
[2] Health plans usually require the member to submit a written request for this information. Instructions for requesting this information can be found on your denial or Explanation of Benefits and in the member benefits summary package). Call your health plan if you need help requesting this information. The member benefits summary package is often available online.

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