

## ■ protect your rights

### You Have The Right To Complain or Appeal

- When an insurance plan will not pay for a treatment or service, you can ask the plan to change (appeal) its decision. Your plan must explain how to appeal when it tells you that it will not pay or cover a service.
- When you appeal, your plan must give you its decision within:
  - 72 hours for denials of urgent care.
  - 30 days for denials of non-urgent care you have not yet received.
  - 60 days for denials of service you have already received.
  - If the plan still denies your benefit, it must explain why and tell you how to ask for an outside review (external review).
- If you do not speak English, you may be able to get appeal information in your native language.

### How To Complain or Appeal

#### 1. Call Member Services – Toll Free Number is on your Health Plan's Card.

- Ask for a complaint or grievance form or in some cases you may file a complaint over the phone.
- Ask your plan to send you a copy of the denial letter.
- Check your plan benefits to make sure that you are being denied a service that is covered by your plan. If you do not have this list of benefits, ask your member services to send you one.

#### tip

- Keep a record of all letters you send or get from your health plan.
- Keep a log of all telephone calls you make or get about your denial.
- Keep a copy of the denial letter (do not assume your health plan will have it on file).

#### 2. Get Information

- Talk with your doctor. Ask for a letter from your doctor stating why you need the service or treatment or why you were given that service or treatment.
- Ask for a copy of any letters that the doctor sent to the health plan for your case.

#### 3. Write Your Complaint or Appeal

Your Letter must have:

- Your plan identification numbers (policy number, group number, claim number)
- The reason for the denial that they explained in the denial letter
- A brief history of the illness and necessary treatment
- Why you believe the decision was wrong
- What you are asking the managed care plan to do

#### 4. What To Do Next

- You will be told in writing of the health plan's decision, why they made that decision and what to do next.
- If your complaint or appeal has been denied you need a copy of the second denial letter. This letter will tell you how to appeal on the next level. You may have to send new information with this second appeal that talks about the current reason for the denial.

#### 5. External or Outside Appeals with the CT Insurance Department

- If you have gone through all levels of the inside appeals in your health plan you may be able to file an outside appeal with the CT Insurance Department.
- You must file for an external appeal within 120 days of getting written notice from your health plan that you have used all of their internal appeals. If your situation is urgent, you have the right to an expedited external appeal.

## ■ choose a plan

- Choosing the right health plan for you and your family is an important decision.
- Know What Your Choices Are:
  - Job-based insurance through you or your spouse.
  - Individual Health Plans (not through your job)
    - Government or Public Health Plans
    - Association Plans
- Compare Health Plans
- There are many things to think about before you choose a plan:
  - Compare services
  - Compare provider networks (doctors, specialists, hospitals, pharmacies that the plan works with)
  - Compare costs
  - Compare quality

#### tip

- If you have a doctor, hospital, or group of physicians you prefer, you should ask them if they participate in any plan that you may consider joining.
- If you have a chronic illness or take certain medicines, ask the plan how you will use the plan to get the care you need.

To Learn More: [ct.gov/oha](http://ct.gov/oha) – under Resources or [healthcare.gov](http://healthcare.gov)  
To Get Help: Call the Office of the Healthcare Advocate: 1.866.HMO.4446



Office of the  
Healthcare  
Advocate  
STATE OF CONNECTICUT

There's help. Call 1.866.HMO.4446

A free service of the State of Connecticut.

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

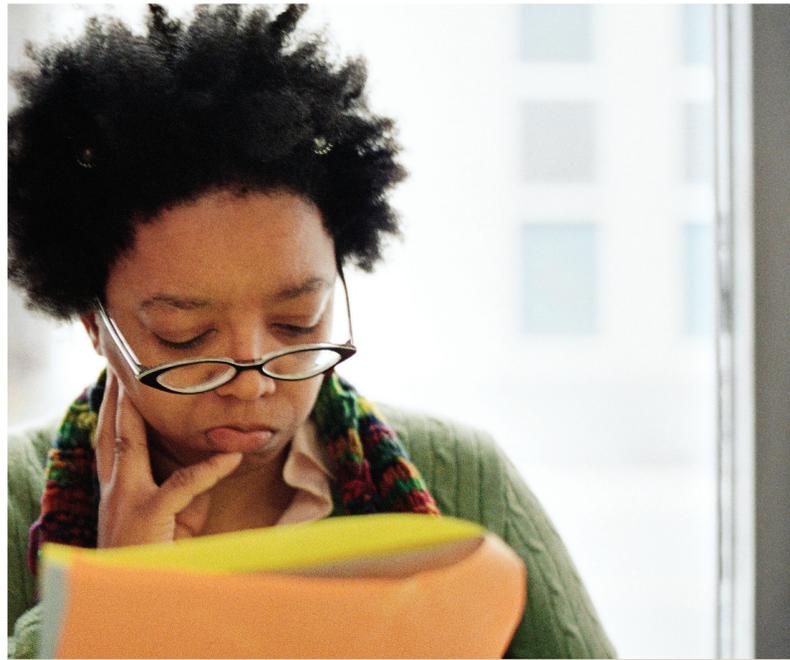


Office of the  
Healthcare  
Advocate  
STATE OF CONNECTICUT

KNOW YOUR RIGHTS  
PROTECT YOUR RIGHTS  
CHOOSE A PLAN



The "Affordable Care Act" is a Federal law that gives Americans new healthcare rights and benefits. This brochure can help you get the facts and know where to go for help.



## ■ know your rights

### Young Adult Children Can Join or Stay on Their Parent's Plan Until Age 26

- Most plans must allow a parent's health plan to cover their adult children up to age 26.
- Adult children under age 26 can join or stay on your plan even if they are not living with you, or if they are in school, or if they are married and even if they do not rely on you for money.

- tip**
- Until 2014, some job-based plans do not have to cover adult children if those children have another type of coverage through their own job.
  - Your plan must give you 30 days from the start of your next "plan year" or "policy year" to sign up your adult child for that plan.

To Learn More: [ct.gov/oha](http://ct.gov/oha) – under Resources or [healthcare.gov](http://healthcare.gov)  
To Get Help: Call the Office of the Healthcare Advocate: 1.866.HMO.4446

### Children Under Age 19 Get Protection

- Health Plans cannot limit or deny benefits to your child younger than age 19 because the child had a health problem before the child applied to that plan. We call this a "pre-existing condition."
- The pre-existing condition can be a physical problem, mental health problem, disability or illness.
- This rule starts as soon as your plan begins a new "plan year" or "policy year" on or after September 23, 2010.

- tip**
- This rule may not be true for some plans that you bought for you or your family on or before March 23, 2010. Ask your plan if it is "grandfathered" from this part of the Affordable Care Act.
  - On or after January 1, 2014, all adults with pre-existing conditions cannot be limited or denied health plan benefits for that condition.

### You Choose the Doctor

- You have the right to choose a primary care doctor or pediatrician from your health plan's provider network. The health plan provider network is all the doctors, specialists and hospitals that work with your plan.
- You do not need a referral to get care from an OB-GYN specialist in your health plan's network.
- Your plan must pay for you to use an emergency room for a true emergency even if that hospital is out of the plan's network. (Please note, if you go out of the plan's network, you may still have to pay for some part of these services).

You may have additional rights under Connecticut law if you are in an individual or fully-insured group plan. Ask your employer if you are in a fully-insured plan or call OHA for help.

- tip**
- This rule may not be true for some plans that you bought for you or your family on or before March 23, 2010. Ask your plan if it is "grandfathered" or exempt from this part of the Affordable Care Act.
  - If your plan is not "grandfathered", these rights start when you start a new plan year or policy year on or after September 23, 2010.

### Get Services That Can Help Keep You Healthy

- If your health plan policy was created after March 23, 2010 your plan must cover some services that can help keep you healthy (preventive services) without charging you a co-payment, co-insurance, or deductible.
- Some of the services include:
  - Blood pressure, diabetes, and cholesterol tests
  - Many cancer screenings, including mammograms and colonoscopies
  - Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use
  - Routine vaccinations against diseases such as measles, polio or meningitis
  - Flu and pneumonia shots
  - Counseling, screening, and vaccines to ensure healthy pregnancies
  - Regular well-baby and well-child visits, from birth to age 21

- tip**
- If your job-based plan or individual health plan existed or was bought on or before March 23, 2010, these wellness and preventive services may not be covered for you without further costs.
  - If the "preventive" service is not the main reason for your visit, your plan may ask you to pay some costs of that office visit.



### Get Some Health Benefits Without Dollar Limits

- Health plans will not be able to put a dollar limit on what they would spend for your "essential" covered benefits during the entire time you were a member of that plan. This is called lifetime dollar limits.

- tip**
- Essential health benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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