The State of New Hampshire
Insurance Department
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SELF-FUNDED or SELF-INSURED PLAN APPEALS
Frequently Asked Questions

The New Hampshire Insurance Department (NHID) regulates individual and fully-insured, group health insurance plans sold in New Hampshire. The state does not regulate self-funded Employee Retirement Income Security Act of 1974 (ERISA) health plans. The regulation of self-funded ERISA health plans rests with the United States Department of Labor. However, a prominent focus of the NHID's mission is consumer protection and education. Therefore, while state regulation of ERISA health plans is preempted by federal law, the Department hopes the following information is helpful to you in understanding your appeal rights.

What is self-insured health plan?

In short, a self-insured health plan is an employer sponsored plan, in which the employer assumes the financial risk for paying claims and providing benefits to its employees.

What if I need help understanding an adverse decision, such as a claim denial?

If you need help understanding the reasons your plan administrator denied a referral, a preauthorization request or a claim, call your plan administrator's Customer Service Department. The administrator's information is on the back of your insurance card.

What if I don't agree with my plan administrator's claim decision?

You may appeal any denied or partially denied claim with your plan administrator. You may also wish contact your employer, as your employer ***may*** be able to approve payment of your claim.

How do I file an appeal?

If you need help understanding the appeal process or the types of adverse decisions which may be appealed, call your plan administrator's Customer Service Department. To file an appeal, submit a written request for reconsideration to your plan's administrator or employer no later than 180 days from the date of the plan's final denial.

How long will it take for me to receive an appeal determination?

Appeal decisions are usually issued within 20-30 days.

What if my situation is urgent?

If your situation is urgent and delaying treatment will jeopardize your life or your long-term health, you and your treating physician may request an expedited appeal. Expedited appeal decisions are usually issued within 72 hours.

Can someone else represent me in my appeal?
Yes. A patient may designate an individual, including the treating health care provider, as his/her representative.

What documents do I need to submit with my appeal?
Each plan may have slightly different requirements. As such, it is important that you contact your plan administrator or employer for specific instructions. In general, the following documentation should be submitted:

- ☐ A photocopy of the front and back of the patient's insurance card or other evidence the patient is insured by the company named in the appeal.
- ☐ A copy of the plan administrator's letter, denying the requested treatment or service.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.

If I am not satisfied with the service provided by my plan administrator or employer, who should I contact?
If you have questions about your appeal rights, need additional assistance or wish to file a grievance concerning the administration of your appeal rights you may contact the Employee Benefits Security Administration at 866-444-EBSA (866-444-3272) or the U.S. Department of Labor at 866-487-2365.

Additional Resources

U.S Department of Labor
https://www.dol.gov/
T: 866-487-2365

Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
T: 866-444-3272

EBSA Consumer Guide - Filing a Claim for Your Health Benefits
https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf