How do you appeal a decision?

How you appeal a decision depends on who makes the decision: either your health insurance company or the Marketplace. The chart below lists the decisions you can appeal, who to appeal those decisions to, and the appeals process.

How to appeal a decision by the Marketplace

If you don't agree with…	You can…	File an expedited (faster) appeal if…
One of these kinds of decisions made by the **Marketplace**: ▪ Whether you're eligible to buy a Marketplace plan, including a Catastrophic health insurance plan ▪ Whether you can enroll in a Marketplace plan outside the regular open enrollment period ▪ Whether you're eligible for lower costs based on your income ▪ The amount of savings you're eligible for ▪ Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP). Note: contact the Marketplace to confirm where to file a Medicaid or CHIP eligibility appeal; the Marketplace may direct you to file this appeal directly with the state Medicaid or CHIP agency. ▪ Whether you're eligible for certain exemptions from the requirement to have health insurance ▪ Whether the Marketplace made a timely determination about your eligibility after you applied	File a standard appeal with **the Marketplace** within **90 days** of the date of your final eligibility determination from the Marketplace or if you are appealing a decision about Medicaid eligibility, you can choose to have your appeal heard by the Medicaid agency instead. If your appeal is to the Marketplace, we may contact you to discuss your appeal and agree to an informal resolution. If you do not agree with the outcome of the informal resolution, you can request a hearing. We will provide more information on the process if you request an appeal. At the end of the appeal process, we will mail you our decision as soon as possible. Marketplace appeal decisions are final and binding. But judicial review may be available.	The time needed for the standard appeal process would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function. Your request to expedite your appeal will be processed as quickly as possible.

For more information, go to: www.healthcare.gov/marketplace-appeals/

How to appeal a decision made by your health insurance plan

If you don't agree with…	You can…	File an expedited (faster) appeal if…
One of these kinds of decisions made by **your health insurance plan**: ▪ Refusing to pay a claim for a benefit, (like a health service, treatment, or prescription drug) you believe should be covered in whole or in part based on the terms of your plan ▪ Ending your coverage ▪ Saying you aren't eligible for coverage after you file a claim	File an appeal with **your health insurance plan**. Your insurance company must first notify you in writing to explain why they denied coverage. They also must let you know how you can appeal their decision. You have at least **180 days** from the time your insurance company notified you in writing of their decision to file an internal coverage appeal. In general, your insurance plan must tell you their decision and mail you their response within: ▪ 30 days if your appeal is for a service that you have not yet received ▪ 60 days if your appeal is for a service that has already been rendered If you don't agree with the decision, you may be able to receive an external review by an independent third party.	The time needed for the standard appeal process would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function. You can file an internal appeal and an external review request at the same time. A final decision about your appeal must come as quickly as your medical condition requires, but within no more than 72 hours after your request is received.
One of these kinds of decisions made by your health insurance plan **after** an **internal review** conducted by the plan: ▪ Any plan's denial of payment for a benefit (like a health service, treatment , or prescription drug) that you think should be covered based on the terms of your plan ▪ Cancellation of coverage, effective back to the date the coverage started (also called a "rescission") **Note:** If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal.	Request an external review by **an independent third party**. See your health plan documents for instructions on how to request an external review. You have at least **60 days** from the receipt of an adverse benefit determination notice or a final internal adverse benefit determination notice to file a request for external review. Some plans may allow you more than 60 days to file your request. The notice sent to you by your health insurance issuer or health plan should tell you the timeframe in which you must make your request. Standard external reviews are decided within no more than **60 days** after the request was received. Some states may require a decision to be made within less than 60 days.	The timeline for the standard external review process would seriously jeopardize your life, health, or ability to regain maximum function. A final decision about your external review request comes as quickly as your medical condition requires, but within no more than 72 hours after your request is received

For more information, go to: www.healthcare.gov/appeal-insurance-company-decision