

internal appeal to your insurer

The first denial of your prescription drug exception request

Notification that your insurer said you didn't need to go through their internal appeal process.

If your insurer offers a second internal appeal, you do not have to file one with them, but if you do, you must still send the External Appeal to DFS within four months of the first appeal decision.

Fees for External Appeal

There may be a \$25 fee. Your fees for all appeals are capped at \$75 a year. There is no fee if you are covered under Medicaid, Child Health Plus, Essential Plan, or if the fee is a hardship. The fee will be returned to you if the denial is overturned. You can also ask for help from Community Health Advocates at **(888) 614-5400** or visit www.communityhealthadvocates.org to ask about financial aid.

Who is Covered by New York Protections?

Individual coverage you buy in New York and group coverage your employer buys in New York are covered by these protections.

If you have Medicaid, Child Health Plus, or the Essential Plan, New York protections apply but there are different rules.

If you have Medicare, different rules apply.

Who is NOT covered by New York Protections

If you have health insurance from another state, or your employer has a group insurance policy from another state (for example, their main office is in another state) the rules of that other state will apply.

If your employer self-funds insurance coverage (many large employers do) New York protections don't apply.

Questions and Complaints

If you have general insurance questions, call DFS at **(800) 342-3736** (Monday through Friday, 8:30 AM to 4:30 PM).

For Medicaid call the New York State Department of Health (DOH) at **(800) 541-2831**.

For Medicare, call CMS at **(800) MEDICARE**, the Medicare Rights Center at **(800) 333-4114**, or visit www.medicarerights.org.

Call Community Health Advocates, New York State's insurance consumer advocacy group at **(888) 614-5400** and/or www.communityhealthadvocates.org.

Complaints

You can file a complaint with DFS or DOH depending on the type of coverage you have.

If you have a complaint about an insurer or HMO, file a complaint with DFS at dfs.ny.gov/complaint.

DFS will investigate your complaint and may share a copy of your complaint with your insurer or refer it to another state agency, if needed.

If you have Medicaid, Essential Plan, or Child Health Plus coverage, file a complaint with DOH. Call **(800) 663-6114** (Monday-Friday 9:00 am - 5:00 pm), or by email at managedcarecomplaint@health.ny.gov



dfs.ny.gov



Health Insurance for Transgender New Yorkers



This guide is provided for informational purposes only and does not constitute legal advice.

If you are a New Yorker and have health care coverage that you or your employer bought in New York State you have certain rights and protections for medically necessary trans-related health care, like hormones and surgery.

Your Insurer Can't Discriminate Against You

Your insurer can't discriminate against you because of your sexual orientation, gender identity or expression, or transgender status.

Your insurer can't refuse to cover you, terminate your coverage, or charge you higher premiums because of your sexual orientation, gender identity or expression, or transgender status.

Your insurer can't deny you medically necessary infertility treatment that they cover because of your sexual orientation, gender identity or expression, or transgender status.

Your insurer can't apply annual or lifetime limits on most treatment.

Your Insurer Must Cover Certain Treatments

Your health insurer cannot exclude Medically Necessary Treatment for "gender dysphoria" such as surgery, hospital stays, mental health care, and office visits.

You can request coverage of a prescription drug that is not on your insurer's list of covered drugs and file an appeal if the insurer issues a denial.

If there is no in-network provider with the training and experience to meet your health care needs, you can ask for care from a qualified out-of-network provider and file an appeal if the insurer issues a denial.

You must ask your insurer to approve services from an out-of-network provider before the services are received. If you do not, you will

lose your right to file an appeal if the insurer issues a denial.

Insurers establish their own clinical review criteria (medical guidelines) for approving and denying benefits, but it must be evidence-based, peer reviewed, and age-appropriate. You have a right to a copy of your insurer's clinical review criteria (medical guidelines) at any time.

What You May Have to Pay

You may have to pay a copayment (set dollar amount) or coinsurance (a percentage of the costs) for treatment, depending on your policy.

If your policy has an out-of-network benefit, costs and cost-sharing for out-of-network providers will usually be higher.

If your employer has more than 100 employees, some benefits, like prescription drugs, are not required to be covered.

What To Do If Your Treatment or Service Is Denied

Coverage for services, referrals to out-of-network providers, and prescription drugs that are not on your insurer's formulary list may be denied.

If a service is denied, your insurer must notify you in writing, or by phone for urgent cases.

You have the right to appeal the decision, and you have 180 days to file that appeal with your insurer.

How to File an Appeal with Your Insurer

If your treatment is denied, your insurer must notify you. Follow the insurer's directions for filing your appeal.

To appeal an out-of-network provider denial, your doctor must send a written statement to your insurer that the in-network providers recommended by your insurer do not have

the training and experience to meet your health care needs and recommend an out-of-network provider with the training and experience to meet your health care needs who is able to provide the service.

To appeal an out-of-network service denial your doctor must send a written statement to your insurer that the out-of-network service is materially different from the in-network service your insurer recommends or approves and provide two documents of medical evidence that the out-of-network service is likely to be more clinically beneficial than the in-network service and is not higher risk.

Remember, you must ask your insurer to approve services from an out-of-network provider before you receive services. If you do not, you will not be eligible for an external appeal.

If your insurer denies the appeal, that's known as a "final adverse determination." You do not have to appeal again to your insurer, you can file an External Appeal with DFS, and the appeal will be reviewed by a medical expert that is not affiliated with your insurer.

How to File an External Appeal

If your insurer issues a "final adverse determination" denying health care services as not medically necessary, experimental/investigational, or out-of-network, you have the right to appeal those denials. This second appeal is known as an External Appeal, and you file it with the New York State Department of Financial Services (DFS).

The External Appeal form is available on the DFS website at www.dfs.ny.gov/externalappeal.

Deadline to Request an External Appeal

You must submit your external appeal to DFS within four months from the date of:

The final adverse determination from the first