Harvard Pilgrim Health Care

This document describes your Medicare Part C medical plan rights including coverage decisions, grievances and appeal processes.

Requesting a coverage decision

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. We make coverage decisions for you whenever you go to a doctor or other provider for medical care. You, your physician, or your designated representative can contact the plan directly to ask for a coverage decision or to ask about the process or the status of a request.

Telephone	TTY:	Facsimile	US Mail
1-888-609-0692	711	1-866-874-0857	Harvard Pilgrim Health Care 1600 Crown Colony Dr. Quincy MA 02169

Customer Service staff are available to assist you between October 1 - March 31, from 8 a.m. to 8 a.m., 7 days a week and April 1 - September 30, from 8 a.m. to 8 p.m., Monday through Friday.

We will process your request through the standard coverage decision process. If your health requires it, you can ask us for an expedited (fast) coverage decision:

Standard coverage decision	**Expedited** (fast) coverage decision
Pre-Service requests: We will notify you of our decision no later than 14 calendar days after receiving your request. **Requests for payment:** We will notify you of our decision no later than 60 calendar days after receiving your request For either request, we can, however, take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.	For pre-service requests, we will notify you of our decision within 72 hours of receipt. We can, however, take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. Payment requests cannot be expedited.

Filing a grievance

A grievance is any complaint or dispute other than a coverage decision, expressing dissatisfaction with the manner in which Harvard Pilgrim provides health care services. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. You need to file your grievance within 60 calendar days after the event. We can extend this deadline if you have a good reason for missing the deadline.

If you have a grievance, we encourage you to first call Harvard Pilgrim's Customer Service department at the number listed below. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we will investigate the issue and call you back with a resolution. There is no form required for filing a grievance. You may submit your complaint over the phone, in writing or via facsimile to Harvard Pilgrim at the address and/or fax number listed below.

Telephone	TTY:	Facsimile	US Mail
1-888-609-0692	711	1-617-509-4232	Harvard Pilgrim Health Care Medicare Advantage Appeals & Grievances P.O. Box 690345 Quincy MA 02269

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

You are also entitled to a quick review of your complaint (expedited grievance) if you disagree with our decision in the following scenarios:

- If we deny your request for an expedited review of a request for medical care
- If we deny your request for an expedited review of an appeal for denied services
- If we decide an extension is needed to review your request for medical care
- If we decide an extension is needed to review your appeal of denied medical care

You may also submit your expedited grievance request verbally, in writing or via facsimile to Harvard Pilgrim at the address and/or fax number listed above. We will quickly review your request and notify you of our decision as expeditiously as your health condition might require, but no later than 24 hours of receiving your complaint.

If your complaint is about quality of care, you can make your complaint to the Quality Improvement Organization (QIO), a group of practicing physicians and other health care experts paid by the federal government to validate and improve the care given to Medicare patients.

To find the QIO for your state please refer to your Evidence of Coverage (Chapter 2, Section 4) located on our website, www.harvardpilgrim.org/medicare. If you make a complaint to this organization, we will work with them to resolve your complaint. If you wish, you can make your complaint about quality of care to both the QIO and Harvard Pilgrim at the same time.

Filing an appeal

An "appeal" is the type of complaint you make when you want us to re-evaluate and change a decision we have made about what benefits are covered for you or what we will pay for a benefit.
If we make a coverage decision and you are not satisfied with this decision, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision. Here are two examples of when you may want to file an appeal:

- We do not cover or pay for a benefit you think we should cover
- We reduce or cut back on coverage you have been receiving

You need to file your appeal within 60 calendar days from the date on the coverage decision (denial letter) that you get from us. Harvard Pilgrim may accept an appeal or redetermination beyond 60 days if you show good cause for an extension.

Appeal review time frames

Standard appeal	Expedited (fast) appeal
Pre-service: We must give you our answer regarding a standard appeal within 30 calendar days if your appeal is about covered services you have not yet received. **Payment:** We must give you our answer regarding a standard appeal within 60 calendar days if your appeal is about payment for a covered service that was denied. For either request, we will give you our decision sooner if your health condition requires us to. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we do not give you our decision within the required time frame, your request will go to an independent review organization where a reconsideration or review will be made.	When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health condition requires us to do so. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you in writing. If we do not give you our decision within 72 hours, your request will automatically go to an independent reviewer where a reconsideration or review will be made.

We may accept or decline your request for an expedited appeal as follows:

- If we decline your request for an expedited appeal, we will process your request through the standard appeal process. If you disagree with our decision not to expedite your request, you may file an expedited grievance (see Filing a Grievance above).
- If we accept your request for an expedited appeal with supporting documentation from your physician, a decision will be made within 72 hours.

To start an appeal, you (or your representative or your doctor or other prescriber) must contact us.

Telephone	TTY:	Facsimile	US Mail
1-888-609-0692	711	1-617-509-4232	Harvard Pilgrim Health Care Medicare Advantage Appeals & Grievances P.O. Box 690345 Quincy MA 02269

If you have any questions about the processes outlined above or for more detailed information, please call our Customer Services department the numbers listed above, or refer to Chapter 9 of your Evidence of Coverage available at www.harvardpilgrim.org/medicare.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare Web site (http://www.medicare.gov).