

Important information about your appeals and grievances rights

Appeals

An **appeal** is the type of complaint you make when you want NaviCareSM HMO to reconsider and change a decision we have made:

- To deny, stop, suspend, or reduce any services
- About what services are covered for you
- About what we will pay for a service

You have the right to appeal. File your appeal in writing, by e-mail, by faxing or contacting an Appeals and Grievances coordinator by telephone within 60 calendar days of receiving the denial notice. NaviCare HMO can give you more time if you have a good reason for missing the deadline.

Who may file an appeal?

You or someone you name to act for you may file an appeal.

There are three kinds of appeals:

Standard (30 days)—You can ask for a standard appeal. We must decide no later than 30 calendar days after we get your appeal. (We may extend this time by up to 14 days if you ask for an extension, or if we need more information and the extra time benefits you.)

If you ask for a standard appeal of a coverage decision about drugs covered under Medicare Part D, we must decide no later than 7 calendar days after we receive your appeal.

Expedited (72-hour review)—You can ask for an expedited (fast) appeal if you or your doctor believes that your health could be seriously harmed by waiting too long for a decision. We must decide on an expedited appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you ask for an extension, or if we need more information and the extra time benefits you.)

If you request an expedited appeal of a coverage decision about drugs covered under Medicare Part D, we must decide no later than 72 hours after we receive your appeal.

Appeal with the MassHealth Board of Hearings (BOH)—You may pursue a MassHealth BOH review in addition to, or instead of, filing an appeal with FCHP.

If you choose to file an appeal with the Board of Hearings, you must send your written hearing request to BOH no later than 30 calendar days from the date of mailing of the FCHP notice to deny coverage for your services. The Member Appeals and Grievances Department may help you with this process.

If you disagree with the BOH decision, there are further levels of appeals available to you, including legal review of the decision under Massachusetts General Law.

What do I include with my appeal?

You should include your name, address, member ID number, reasons for appealing and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide coverage for the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person.

How do I request an appeal?

For a standard appeal

You, or the person you choose to represent you, should mail, fax or deliver your written appeal request to:

NaviCare HMO
c/o Fallon Community Health Plan
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608
Fax: 1-508-755-7393

Or, you may contact us by e-mail at: grievance@fchp.org

For an expedited appeal

You, or the person you choose to represent you, should contact us by telephone or fax at:

Toll-free: 1-877-700-6996 (TDD/TTY: 1-877-795-6526)
Monday through Friday, from 8 a.m. to 6 p.m.
Fax: 1-508-755-7393

Or, you may contact us by e-mail at: grievance@fchp.org

Appeal with the MassHealth Board of Hearings (BOH)

You or your appointed representative should submit a written request for a BOH review to:

Board of Hearings
Office of Medicaid
2 Boylston Street
Boston, MA 02116
Fax: 1-617-210-5820

What happens next?

If you appeal, we will review our decision. After we review our decision, if payment for any of your claim is still denied, we will automatically forward your request to MAXIMUS Federal Services, Inc., an independent company chosen by the Centers for Medicare & Medicaid Services (CMS), for a new and impartial review of your case. If you disagree with the MAXIMUS decision, you may then submit your appeal to the administrative law judge, providing that the dollar value of the services in the appeal is \$100 or more.

Contact information

If you need information or help, call to speak to a NaviCare HMO Enrollee Service Representative at 1-877-700-6996 (TDD/TTY: 1-877-795-6526).

Other resources to help you

Medicare Rights Center: 1-888-HMO-9050
Elder Care Locator: 1-800-677-1116
Medicare: 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048

Exceptions to the formulary (list of covered medications)

You can ask NaviCare HMO to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.

- You can ask us to remove coverage restrictions or limits on your drug. For example, for certain drugs, NaviCare HMO may limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to remove the limit and cover more.

Generally, NaviCare HMO will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional restrictions on use would not be as effective in treating your condition and/or would cause you to have adverse medical effects. Please note that because we do not cover drugs to treat erectile dysfunction (E.D.), you will not be able to request a formulary exception for E.D. drugs when used to treat E.D.

You should contact us to ask us for a preliminary coverage decision for a coverage exception. When you are requesting a coverage exception, you should submit a statement from your doctor supporting your request. Generally, we must make our decision within 72 hours of getting your doctor's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must decide no later than 24 hours after we get your doctor's supporting statement.

Grievances

A grievance is the type of complaint you make if you have any other type of problem with Fallon Community Health Plan, NaviCare HMO or one of our plan providers. 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
- Getting the information you need
- The cleanliness or condition of the doctor's office

How do I file a grievance?

Call the NaviCare HMO Member Appeals and Grievances Department at:

1-877-700-6996 (TDD/TTY: 1-877-795-6526)
Monday through Friday, from 8 a.m. to 6 p.m.

Or, send a letter including all details of your grievance to:

NaviCare HMO
c/o Fallon Community Health Plan
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

A NaviCare HMO Member Appeals and Grievances coordinator representative will let you know that we received your letter within 5 calendar days of the day we receive it. Every reasonable attempt will be made to resolve your complaint within 30 days.

For more information about your appeals and grievances rights, call a NaviCare HMO Enrollee Service Representative at 1-877-700-6996 (TDD/TTY: 1-877-795-6526), seven days a week from 8 a.m. to 8 p.m.



FCHP is a health plan with a Medicare contract.