Member Rights &Responsibilities - Complaint & Appeal Procedures

Overview

The process to communicate grievances to your health plan is called the Complaint and Appeal process. We have established this process to address your issues in a timely manner. An appeal is your right to challenge a denial decision made either by your health care provider or the plan concerning health care benefits. Information about this process is also available in more detail in your Evidence of Coverage and, as always, our Customer Services representatives are available to assist you in either situation.

Complaint Process

A complaint is an expression of dissatisfaction with the quality of care, quality of service, or administrative process. If you have a complaint about billing, we would consider it an administrative complaint. An example of a quality of service complaint is excessive waiting time in your doctor's office. A quality of care complaint would concern the health care that you are receiving. To express a complaint, you can contact us by telephone, mail, or online at www.aetna.com. You can call our Customer Services Department at the number printed on your ID card with any questions, problems, or concerns.

Appeal Process

An appeal is an expression of dissatisfaction with a previous decision made regarding your health care benefits. You or your representative's request for a review of the denial will be handled in a timely manner. When you make an appeal, we will send you a written notice within 5 calendar days that we have received your request. We will also review your appeal and will send you a decision within 30 calendar days upon receipt of your appeal. If we are not able to reach a decision, we will still contact you within the timeframes given above and will tell you why there is a delay and when we hope to resolve your appeal. This process is known as a **Standard Appeal Process**.

An appeal can also be expedited if a plan member has a terminal illness and the appeal involves an experimental or investigational issue. Another type of expedited appeal is for cases involving an imminent and serious threat to the health of the patient, including but not limited to severe pain and potential loss of life, limb, or major bodily function. When the Plan determines that a case meets criteria for an expedited appeal, the member has the right to notify the California Department of Managed Health Care (DMHC) of the complaint. Cases meeting expedited criteria are resolved within three (3) days. In these situations, we encourage you to speak with your health care provider to explore these options.

Independent Arbitration

Finally, we realize that you may not be satisfied with our decision on your appeal. At that time, you may request in writing that the matter be sent to an independent arbitrator. The Plan follows all of the rules laid out by the American Arbitration Association (AAA). The AAA decision is binding. Fees for the arbitration are shared by the plan member and the Plan unless the arbitrator decides that there is a hardship and that a portion or all of the plan member's share shall be paid by the Plan.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-756-7039 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web Site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Department of Labor

As a member, you (or your Plan) may have other voluntary alternative dispute resolution options such as mediation. Please contact your Plan Administrator, local U.S. Department of Labor Office or your State regulatory agency. In addition, you have the right to bring civil action under Section 502(a) of ERISA, if applicable.