

### **Right to Request an Amendment**

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. Your request should be sent to our Member Services Department at the address listed in the "Complaints" section of this Notice.

We will deny your request if you fail to submit it in writing or if you fail to include the reasons for your request. We may also deny your request if you ask us to amend information that is (1) accurate and complete, (2) not part of the medical information that SCAN Health Plan keeps, (3) not part of the information that you would be entitled to inspect and copy, or (4) not created by SCAN Health Plan, unless the creator of the information is not available to amend it.

If we deny your request, we will provide you a written explanation. This letter will tell you how you can file a complaint with us or with the Secretary of the Department of Health and Human Services. It will also tell you about the right you have to file a statement disagreeing with our denial and other rights you may have.

If we accept your request to amend the information, we will make the changes requested in your amendment. But first we will contact you to identify the persons you want notified and to get your approval for us to do so. We will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information.

### **Right to Receive Confidential Communications**

You have the right to request that we communicate with you in confidence about your health information by alternative means or to an alternative location (e.g., mail to a post office box address or fax to a designated number). Your request must be made in writing and must clearly state that if the request is not granted it could endanger the member. SCAN Health Plan will accommodate reasonable requests.

### **Right to Receive an Accounting of Disclosures**

You have the right to receive an accounting of disclosures regarding your health information. Typically the accounting would include disclosures found in the section titled "Other Permitted Uses and Disclosures". The accounting will not cover those disclosures made for the purposes of treatment, payment, and health care operations, and ones that you have authorized.

All requests for an accounting must be in writing and must include specific information needed to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003, unless you request a lesser period of time. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee to produce the accounting of disclosures. Before doing so, we will notify you of the fee, and give you an opportunity to withdraw or limit your request in order to reduce the fee.

### **Right to Receive Notice of a Breach of Protected Health Information**

You have the right to receive a notice of the unauthorized acquisition, access, or disclosure of your health information. SCAN will provide any legally required notices of any unauthorized use acquisition, access, or disclosure of your health information.

### **Right to Copies of this Notice**

You have the right to receive an additional copy of this Notice at any time.

If you have any questions about our Notice of Privacy Practices or would like to request an additional copy of the Notice, please contact the Privacy Office at 1-562-997-3134 or 1-855-895-7226, TTY users call: 711. Or, you can write to:

**SCAN Health Plan**  
Attention: Privacy Office  
3800 Kilroy Airport Way, P.O. Box 22616  
Long Beach, CA 90801-5616

Or email the Privacy Office at [PrivacyOffice@scanhealthplan.com](mailto:PrivacyOffice@scanhealthplan.com), or fax to 1-562-308-3689.

You may also visit our website online and download a printable version of the Notice at [www.scanhealthplan.com](http://www.scanhealthplan.com).

### **How to Complain About Our Privacy Practices**

If you believe SCAN Health Plan has violated your privacy rights, or you disagree with a decision we made about access to your health information you may submit a written complaint to the SCAN Health Plan Privacy Office.

### **Complaints to SCAN Health Plan**

If you want to file a complaint with us, write to:

**SCAN Health Plan**  
Attention: Privacy Officer  
3800 Kilroy Airport Way, P.O. Box 22616  
Long Beach, CA 90801-5616

Or email [PrivacyOffice@scanhealthplan.com](mailto:PrivacyOffice@scanhealthplan.com), or fax to 1-562-308-3689.

If you need assistance with filing a complaint you can call the SCAN Health Plan Privacy Officer at 1-562-997-3134 or 1-855-895-7226.

## **Complaints to the Federal Government**

You may also notify the Secretary of the US Department of Health and Human Services to file a complaint with the federal government.

SCAN Health Plan supports your right to protect the privacy of your personal and health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Filing a complaint will not affect your benefits under SCAN Health Plan or Medicare.

## **How to Obtain Additional Information About this Notice**

If you have any questions about our Notice of Privacy Practices or would like to request an additional copy of the Notice, please contact the Privacy Officer 1-855-895-7226, 8 a.m.–5 p.m. Pacific Standard Time, Monday through Friday. TTY users call: 711.

## **Changes to this Notice**

The terms of this Notice apply to all records containing your health information that are created or retained by SCAN Health Plan. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to the Notice will be effective for all of your records that we have created or maintained in the past. Such revision or amendment shall also be effective for any of your records that we may create or maintain in the future. If we do revise this Notice you will receive a copy.

<b>Section 1.5</b>	<b>We must give you information about the plan, its network of providers, and your covered services</b>
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As a member of SCAN Employer Group, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

- For a list of the providers and pharmacies in the plan's network, see the *Provider & Pharmacy Directory*.
- For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at [www.scanhealthplan.com](http://www.scanhealthplan.com).
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

**Section 1.6**

**We must support your right to make decisions about your care**

**You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

### **You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

For additional Advanced Directive information you can access  
[http://oag.ca.gov/consumers/general/adv\\_hc\\_dir](http://oag.ca.gov/consumers/general/adv_hc_dir)

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance

directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### **What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the California Department of Health Care Services.

<b>Section 1.7</b>	<b>You have the right to make complaints and to ask us to reconsider decisions we have made</b>
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

**Section 1.8      What can you do if you believe you are being treated unfairly or your rights are not being respected?**

**If it is about discrimination, call the Office for Civil Rights**

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

**Is it about something else?**

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Section 1.9      How to get more information about your rights**

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Pubs/pdf/11534.pdf>.)
  - Or, 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.

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## **SECTION 2      You have some responsibilities as a member of the plan**

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<b>Section 2.1      What are your responsibilities?</b>
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:



- In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.



## CHAPTER 9

*What to do if you have a problem  
or complaint (coverage decisions,  
appeals, complaints)*

**Chapter 9. What to do if you have a problem or complaint**  
**(coverage decisions, appeals, complaints)**

<b>BACKGROUND .....</b>	<b>171</b>
<b>SECTION 1 Introduction.....</b>	<b>171</b>
Section 1.1 What to do if you have a problem or concern .....	171
Section 1.2 What about the legal terms? .....	171
<b>SECTION 2 You can get help from government organizations that are not connected with us.....</b>	<b>172</b>
Section 2.1 Where to get more information and personalized assistance .....	172
<b>SECTION 3 To deal with your problem, which process should you use? .....</b>	<b>172</b>
Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? .....	172
<b>COVERAGE DECISIONS AND APPEALS .....</b>	<b>173</b>
<b>SECTION 4 A guide to the basics of coverage decisions and appeals.....</b>	<b>173</b>
Section 4.1 Asking for coverage decisions and making appeals: the big picture.....	173
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal.....	174
Section 4.3 Which section of this chapter gives the details for your situation?.....	175
<b>SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal.....</b>	<b>176</b>
Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care .....	176
Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want).....	177
Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan).....	180
Section 5.4 Step-by-step: How a Level 2 Appeal is done .....	183
Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?.....	185

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

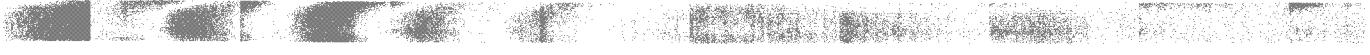
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<b>SECTION 6</b>	<b>Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.....</b>	<b>186</b>
Section 6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug.....	186
Section 6.2	What is an exception?.....	188
Section 6.3	Important things to know about asking for exceptions .....	189
Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception	190
Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) .....	193
Section 6.6	Step-by-step: How to make a Level 2 Appeal.....	195
<b>SECTION 7</b>	<b>How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon .....</b>	<b>197</b>
Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights .....	197
Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date .....	198
Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date .....	201
Section 7.4	What if you miss the deadline for making your Level 1 Appeal?.....	202
<b>SECTION 8</b>	<b>How to ask us to keep covering certain medical services if you think your coverage is ending too soon .....</b>	<b>205</b>
Section 8.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services .....	205
Section 8.2	We will tell you in advance when your coverage will be ending.....	205
Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	206
Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	208
Section 8.5	What if you miss the deadline for making your Level 1 Appeal?.....	210
<b>SECTION 9</b>	<b>Taking your appeal to Level 3 and beyond .....</b>	<b>212</b>
Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals.....	212
Section 9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals .....	213

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

<b>MAKING COMPLAINTS .....</b>	<b>215</b>
<b>SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns .....</b>	<b>215</b>
Section 10.1 What kinds of problems are handled by the complaint process? .....	215
Section 10.2 The formal name for “making a complaint” is “filing a grievance” .....	217
Section 10.3 Step-by-step: Making a complaint .....	217
Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization.....	219
Section 10.5 You can also tell Medicare about your complaint.....	220



## **BACKGROUND**

### **SECTION 1 Introduction**

#### **Section 1.1 What to do if you have a problem or concern**

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

#### **Section 1.2 What about the legal terms?**

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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## **SECTION 2      You can get help from government organizations that are not connected with us**

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<b>Section 2.1      Where to get more information and personalized assistance</b>
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Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

### **Get help from an independent government organization**

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

### **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 website (<http://www.medicare.gov>).

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## **SECTION 3      To deal with your problem, which process should you use?**

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<b>Section 3.1      Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</b>
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

**Is your problem or concern about your benefits or coverage?**

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

**Yes.** My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and appeals.”**

**No.** My problem is not about benefits or coverage.

Skip ahead to **Section 10** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

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**COVERAGE DECISIONS AND APPEALS**

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**SECTION 4 A guide to the basics of coverage decisions and appeals**

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**Section 4.1 Asking for coverage decisions and making appeals: the big picture**

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

**Asking for coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

**Making an appeal**

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 we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

<b>Section 4.2</b>	<b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at [www.scanhealthplan.com](http://www.scanhealthplan.com).) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

**Section 4.3 Which section of this chapter gives the details for your situation?**

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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**SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal**

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- Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

<b>Section 5.1</b>	<b>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
  - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
    - Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
    - Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.
  - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

**Which of these situations are you in?**

<b>If you are in this situation:</b>	<b>This is what you can do:</b>
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, <b>Section 5.2</b> .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an <b>appeal</b> . (This means you are asking us to reconsider.) Skip ahead to <b>Section 5.3</b> of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to <b>Section 5.5</b> of this chapter.

**Section 5.2 Step-by-step: How to ask for a coverage decision  
(how to ask our plan to authorize or provide the medical care coverage you want)**

**Legal Terms**

When a coverage decision involves your medical care, it is called an “**organization determination**.”

**Step 1:** You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “**fast coverage decision**.”

**Legal Terms**

A “fast coverage decision” is called an “**expedited determination**.”

**How to request coverage for the medical care you want**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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***Generally we use the standard deadlines for giving you our decision***

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can 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.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

***If your health requires it, ask us to give you a “fast coverage decision”***

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can 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.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

**Step 2: We consider your request for medical care coverage and give you our answer.*****Deadlines for a “fast coverage decision”***

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

***Deadlines for a “standard coverage decision”***

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

### **Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

<b>Section 5.3</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)</b>
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<b>Legal Terms</b>
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An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
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**Step 1: You contact us and make your appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

#### **What to do**

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at



www.scanhealthplan.com). While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

<b>Legal Terms</b>
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A “fast appeal” is also called an “ <b>expedited reconsideration.</b> ”
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***If your health requires it, ask for a “fast appeal” (you can make a request by calling us)***

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

**Step 2: We consider your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

### ***Deadlines for a “fast appeal”***

- 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 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 an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

### ***Deadlines for a “standard appeal”***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. 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 you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

**Step 3:** If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

<b>Section 5.4</b>	<b>Step-by-step: How a Level 2 Appeal is done</b>
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If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>
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The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1:** The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

**If you had a “fast appeal” at Level 1, you will also have a “fast appeal” at Level 2**

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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***If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2***

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

**Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

**Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?**

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

**Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

**We will say yes or no to your request**

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

**What if you ask for payment and we say that we will not pay?**

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

**To make this appeal, follow the process for appeals that we describe in part 5.3 of this section.** Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the

answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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## SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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- Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

<b>Section 6.1</b>	<b>This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug</b>
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Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

### Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

<b>Legal Terms</b>
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An initial coverage decision about your Part D drugs is called a “ <b>coverage determination.</b> ”
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

**Which of these situations are you in?**

<p><b>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</b></p>	<p><b>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</b></p>	<p><b>Do you want to ask us to pay you back for a drug you have already received and paid for?</b></p>	<p><b>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</b></p>
<p>You can ask us to make an exception. (This is a type of coverage decision.) Start with <b>Section 6.2</b> of this chapter.</p>	<p>You can ask us for a coverage decision. Skip ahead to <b>Section 6.4</b> of this chapter.</p>	<p>You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to <b>Section 6.4</b> of this chapter.</p>	<p>You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to <b>Section 6.5</b> of this chapter.</p>

**Section 6.2 What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

**Legal Terms**

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (Non-Preferred Brand Drugs Tier) for brand name drugs or Tier 2 (Generic Drugs Tier) for generic drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

**Legal Terms**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

**Legal Terms**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

- If your drug is in Tier 3: Preferred Brand Drugs (applicable to select generic drugs or select brand-name drugs only), you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2: Generic Drugs or to drugs in Tier 6: Select Care Drugs. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5: Specialty Tier Drugs.

**Section 6.3 Important things to know about asking for exceptions****Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

**We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception**

**Step 1:** You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast coverage decision.” You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

**What to do**

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- A request can be submitted through our website via email to:  
medicarepartdparequests@express-scripts.com

**Legal Terms**

A “fast coverage decision” is called an “expedited coverage determination.”

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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***If your health requires it, ask us to give you a “fast coverage decision”***

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast complaint,” which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

**Step 2: We consider your request and we give you our answer.*****Deadlines for a “fast coverage decision”***

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

***Deadlines for a "standard coverage decision" about a drug you have not yet received***

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

***Deadlines for a "standard coverage decision" about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

**Section 6.5 Step-by-step: How to make a Level 1 Appeal  
(how to ask for a review of a coverage decision made by our plan)**

**Legal Terms**

An appeal to the plan about a Part D drug coverage decision is called a plan  
“redetermination.”

**Step 1:** You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

**What to do**

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact us when you are making an appeal about your part D prescription drugs).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

**Legal Terms**

A “fast appeal” is also called an “expedited redetermination.”

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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### ***If your health requires it, ask for a “fast appeal”***

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

### **Step 2: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

### ***Deadlines for a “fast appeal”***

- If 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 requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### ***Deadlines for a “standard appeal”***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast appeal.”
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### **Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

### **Section 6.6 Step-by-step: How to make a Level 2 Appeal**

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

#### **Legal Terms**

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

**Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.**

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

***Deadlines for “fast appeal” at Level 2***

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours** after we receive the decision from the review organization.

***Deadlines for “standard appeal” at Level 2***

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

**What if the review organization says no to your appeal?**

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

**Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).



## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

### SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

#### Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

**Legal Terms**

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

**2. You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

**3. Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 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 also see it online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

**Section 7.2****Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date**

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

***What is the Quality Improvement Organization?***

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

***How can you contact this organization?***

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

**Ask for a “fast review”:**

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

**Legal Terms**

A **“fast review”** is also called an **“immediate review”** or an **“expedited review.”**

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

**What happens during this review?**

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**Legal Terms**

This written explanation is called the **“Detailed Notice of Discharge.”** You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at <http://www.cms.hhs.gov/BNl/>

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

**What happens if the answer is yes?**

- If the review organization says yes to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

**What happens if the answer is no?**

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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**hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 7.3</b>	<b>Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date</b>
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)*****If the review organization says no:***

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Section 7.4      What if you miss the deadline for making your Level 1 Appeal?****You can appeal to us instead**

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

**Step-by-Step: How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

**Legal Terms**

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

**Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

**Step 2: We do a “fast review” of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

**Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

**Step-by-Step: Level 2 Alternate Appeal Process**

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

**Legal Terms**

The formal name for the “Independent Review Organization” is the **“Independent Review Entity.”** It is sometimes called the **“IRE.”**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

**Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.



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## **SECTION 8      How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

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<b>Section 8.1</b>	<b><i>This section is about three services only:</i></b> <b>Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

<b>Section 8.2</b>	<b>We will tell you in advance when your coverage will be ending</b>
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- 1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

<b>Legal Terms</b>
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**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Legal Terms**

In telling you what you can do, the written notice is telling how you can request a “**fast-track appeal.**” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

The written notice is called the “**Notice of Medicare Non-Coverage.**” To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

**2. You must sign the written notice to show that you received it.**

- You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

**Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time**

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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**Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.**

***What is the Quality Improvement Organization?***

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

***How can you contact this organization?***

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

***What should you ask for?***

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

***Your deadline for contacting this organization.***

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

<b>Legal Terms</b>
This notice of explanation is called the " <b>Detailed Explanation of Non-Coverage.</b> "

**Step 3:** Within one full day after they have all the information they need, the reviewers will tell you their decision.

***What happens if the reviewers say yes to your appeal?***

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

***What happens if the reviewers say no to your appeal?***

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

**Step 4:** If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 8.4</b>	<b>Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time</b>
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.*****What happens if the review organization says yes to your appeal?***

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

***What happens if the review organization says no?***

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Section 8.5      What if you miss the deadline for making your Level 1 Appeal?**

**You can appeal to us instead**

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

**Step-by-Step: How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

**Legal Terms**

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

**Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

**Step 2: We do a “fast review” of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

**Step 4:** If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

### Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

**Step 1:** We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

**Step 2:** The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

### **Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## **SECTION 9 Taking your appeal to Level 3 and beyond**

### **Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals**

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal: A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."**

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal:** The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal:** A judge at the Federal District Court will review your appeal.

- This is the last step of the administrative appeals process.

**Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals**

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal: A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."**

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

## **MAKING COMPLAINTS**

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### **SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns**

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- If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

<b>Section 10.1 What kinds of problems are handled by the complaint process?</b>
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This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems, you can “make a complaint”**

<b>Complaint</b>	<b>Example</b>
<b>Quality of your medical care</b>	<ul style="list-style-type: none"><li>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</li></ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"><li>• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?</li></ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"><li>• Has someone been rude or disrespectful to you?</li><li>• Are you unhappy with how our Member Services has treated you?</li><li>• Do you feel you are being encouraged to leave the plan?</li></ul>
<b>Waiting times</b>	<ul style="list-style-type: none"><li>• Are you having trouble getting an appointment, or waiting too long to get it?</li><li>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?<ul style="list-style-type: none"><li>○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.</li></ul></li></ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"><li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?</li></ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"><li>• Do you believe we have not given you a notice that we are required to give?</li><li>• Do you think written information we have given you is hard to understand?</li></ul>

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
<p><b>Timeliness</b> (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> <li>• If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint.</li> <li>• If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.</li> <li>• When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.</li> <li>• When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.</li> </ul>

### Section 10.2 The formal name for “making a complaint” is “filing a grievance”

#### Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

### Section 10.3 Step-by-step: Making a complaint

#### Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. (Phone numbers are printed on the back cover of this booklet.)

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- **Who may file a grievance?**

As a SCAN member you may file a grievance yourself or appoint someone to do it for you. The person you appoint would be your authorized representative. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website <http://www.scanhealthplan.com>) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you have authorized to act on your behalf. You must give us a copy of the signed form.

- **Filing a grievance with your Plan**

If you have a complaint, you or your representative may call the plan for Part C Grievances (for complaints about Part C medical care or services) and/or Part D Grievances (for complaints about Part D drugs or services). You will find phone numbers listed in Chapter 2, SECTION 1 of this booklet, SCAN Employer Group contacts (*How to contact us, including how to reach Member Services at the plan*). We will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the grievance process. In the grievance process we will respond to you in writing if you ask for a written response, file a written grievance, or your complaint is related to quality of care.

You may submit your grievance in writing or verbally. To send a grievance in writing, send it to the address listed in Chapter 2, SECTION 1 of this booklet, SCAN Employer Group contacts (*How to contact us, including how to reach Member Services at the plan*). The grievance must be submitted within 60 calendar days of the event or incident. We must address 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 time frame by up to 14 calendar days if you ask for an extension, or if we justify a need to obtain additional information, and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you an answer within 24 hours.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Legal Terms**

What this section calls a “fast complaint” is also called an “expedited grievance.”

**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

**Section 10.4      You can also make complaints about quality of care to the Quality Improvement Organization**

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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**Section 10.5      You can also tell Medicare about your complaint**

You can submit a complaint about SCAN Employer Group directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.





## CHAPTER 10

*Ending your membership in the plan*

## **Chapter 10. Ending your membership in the plan**

<b>SECTION 1</b>	<b>Introduction.....</b>	<b>224</b>
Section 1.1	This chapter focuses on ending your membership in our plan.....	224
<b>SECTION 2</b>	<b>When can you end your membership in our plan? .....</b>	<b>224</b>
Section 2.1	You can end your membership during the Annual Enrollment Period .....	224
Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited.....	225
Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period.....	226
Section 2.4	Where can you get more information about when you can end your membership? .....	227
<b>SECTION 3</b>	<b>How do you end your membership in our plan? .....</b>	<b>227</b>
Section 3.1	Usually, you end your membership by enrolling in another plan .....	227
<b>SECTION 4</b>	<b>Until your membership ends, you must keep getting your medical services and drugs through our plan.....</b>	<b>228</b>
Section 4.1	Until your membership ends, you are still a member of our plan .....	228
<b>SECTION 5</b>	<b>SCAN Employer Group must end your membership in the plan in certain situations .....</b>	<b>229</b>
Section 5.1	When must we end your membership in the plan?.....	229
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health .....	230
Section 5.3	You have the right to make a complaint if we end your membership in our plan.....	230



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## SECTION 1 Introduction

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<b>Section 1.1</b> <b>This chapter focuses on ending your membership in our plan</b>
--

Ending your membership in SCAN Employer Group may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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## SECTION 2 When can you end your membership in our plan?

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Contact your former Employer Benefits Administrator for ending your membership.

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

<b>Section 2.1</b> <b>You can end your membership during the Annual Enrollment Period</b>
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** Contact your former Employer Benefits for Annual Enrollment Period.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming

year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

<b>Section 2.2</b>	<b>You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited</b>
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**May not be applicable for our Employer Group members. For disenrollment information contact your former Employer Group Benefits Administrator.**

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

**Section 2.3**      **In certain situations, you can end your membership during a Special Enrollment Period**

In certain situations, members of SCAN Employer Group may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
  - Usually, when you have moved.
  - If you have Medi-Cal (Medicaid).
  - If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – or – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

**Section 2.4**      **Where can you get more information about when you can end your membership?**

If you have any questions or would like more information on when you can end your membership:

- Contact your former Employer Benefits Administrator.
- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2016* Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**SECTION 3**      **How do you end your membership in our plan?**

**Section 3.1**      **Usually, you end your membership by enrolling in another plan**

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- Contact your former Employer Benefits Administrator.
- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"><li>• Another Medicare health plan.</li><li>•</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare health plan. You will automatically be disenrolled from SCAN Employer Group when your new plan's coverage begins.</li></ul>
<ul style="list-style-type: none"><li>• Original Medicare <i>with</i> a separate Medicare prescription drug plan.</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from SCAN Employer Group when your new plan's coverage begins.</li></ul>
<ul style="list-style-type: none"><li>• Original Medicare <i>without</i> a separate Medicare prescription drug plan.<ul style="list-style-type: none"><li>○ <b>Note:</b> If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.</li></ul></li></ul>	<ul style="list-style-type: none"><li>• <b>Send us a written request to disenroll.</b> Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).</li><li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li><li>• You will be disenrolled from SCAN Employer Group when your coverage in Original Medicare begins.</li></ul>

## **SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our plan**

### **Section 4.1      Until your membership ends, you are still a member of our plan**

If you leave SCAN Employer Group, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).



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## **SECTION 5      SCAN Employer Group must end your membership in the plan in certain situations**

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<b>Section 5.1      When must we end your membership in the plan?</b>
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**SCAN Employer Group must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for three calendar months.
  - We must notify you in writing that you have three calendar months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

### **Where can you get more information?**

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

**Section 5.2      We cannot ask you to leave our plan for any reason related to your health**

SCAN Employer Group is not allowed to ask you to leave our plan for any reason related to your health.

**What should you do if this happens?**

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week

**Section 5.3      You have the right to make a complaint if we end your membership in our plan**

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10 for information about how to make a complaint.



# CHAPTER 11

*Legal notices*

**Chapter 11. Legal notices**

<b>SECTION 1</b>	<b>Notice about governing law.....</b>	<b>234</b>
<b>SECTION 2</b>	<b>Notice about non-discrimination .....</b>	<b>234</b>
<b>SECTION 3</b>	<b>Notice about Medicare Secondary Payer subrogation rights .....</b>	<b>234</b>
<b>SECTION 4</b>	<b>Binding Arbitration .....</b>	<b>234</b>



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## **SECTION 1      Notice about governing law**

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Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medi-Cal (Medicaid) Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

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## **SECTION 2      Notice about non-discrimination**

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We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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## **SECTION 3      Notice about Medicare Secondary Payer subrogation rights**

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We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, SCAN Employer Group, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

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## **SECTION 4      Binding Arbitration**

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New members who enroll with SCAN Health Plan, with an effective date that falls on or after March 1, 2008, receive within their post-enrollment materials, an Arbitration Opt-Out Card that they may use to opt out of binding arbitration. These members have one opportunity to opt out of binding arbitration by returning the Arbitration Opt-Out Card to SCAN Health Plan within 60-days of their SCAN Health Plan enrollment application date, according to the instructions provided on the card.

The following description of binding arbitration applies to the following members:

- All members enrolled in SCAN Health Plan who enrolled with an effective date prior to 3/1/08; and
- All members enrolled in SCAN Health Plan with an effective date of 3/1/08 or after who have not expressly opted out of the binding arbitration process by submitting the Arbitration Opt-Out Card that was included within their post-enrollment materials at the time of enrollment.

**Chapter 11. Legal notices**

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- For all claims subject to this “Binding Arbitration” provision, both Claimants and Respondents (as defined below) give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this “Binding Arbitration” provision applies to claims asserted by SCAN Health Plan Parties (as defined below), it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the SCAN Health Plan Parties.

**Scope of Arbitration**

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party’s (as defined below) relationship to SCAN Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services, irrespective of the legal theories upon which the claim is asserted.
- The claim is asserted by one or more Member Parties against one or more SCAN Health Plan Parties or by one or more SCAN Health Plan Parties against one or more Member Parties.
- The claim is not within the jurisdiction of the small claims court.
- The claim is not subject to a Medicare appeal procedure.

As referred to in this “Binding Arbitration” provision, “Member Parties” include:

- A member.
- A member’s heir, relative, or personal representative.
- Any person claiming that a duty to him or her arises from a member’s relationship to one or more SCAN Health Plan Parties.

“SCAN Health Plan Parties” include:

- SCAN Health Plan.
- SCAN Group and any of its subsidiaries.
- Any employee or agent of any of the foregoing.

“Claimant” refers to a Member Party or a SCAN Health Plan Party who asserts a claim as described above. “Respondent” refers to a Member Party or a SCAN Health Plan Party against whom a claim is asserted.

**Arbitration Administered By JAMS**

Claimants shall submit any dispute subject to binding arbitration to JAMS (an organization that provides arbitration services) for resolution by final and binding arbitration before a single arbitrator. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

**Chapter 11. Legal notices**

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Claimants shall initiate arbitration by submitting a demand for arbitration to JAMS. Please contact JAMS at the telephone number or email address provided below in order to submit a demand for arbitration.

The demand for arbitration shall include the basis of the claim against the Respondents; the amount of damages Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorneys, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Administration of the arbitration will be performed by JAMS in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. Claimants and Respondents will endeavor to mutually agree to the appointment of the arbitrator. But if an agreement cannot be reached within thirty (30) days following the date that demand for arbitration is made, the arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be used.

Arbitration hearings will be held in Los Angeles, California or at another location that Claimants and Respondents agree to in writing. Civil discovery may be taken in the arbitration as provided by California law and California Code of Civil Procedure. The arbitrator selected will have the power to control the time, scope, and manner of the taking of discovery. The arbitrator will also have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California, including but not limited to, imposing sanctions. The arbitrator will have the power to grant all remedies provided by California law.

The arbitrator will prepare in writing an award that includes the legal and factual reasons for the decision. The award will include the allocation of the proceeding's fee and expenses between parties. The requirement of binding arbitration will not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction. However, any and all other claims or causes of action, including but not limited to, those seeking damages, will be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will apply to the arbitration.

Should you have any questions regarding initiating binding arbitration, please contact JAMS at 1-800-352-5267, or on the Internet at [www.jamsadr.com](http://www.jamsadr.com).





# CHAPTER 12

*Definitions of important words*

## **Chapter 12. Definitions of important words**

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Annual Enrollment Period** – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

**Balance Billing** – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of SCAN Employer Group, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,850 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

**Complaint** - The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

**Compounded Drug** – A prescription medication that is prepared by mixing or altering an existing drug to produce the specific formulation or a dose strength that is not commercially available. Compounded drugs are not approved by the Food and Drug Administration.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

**Cost-sharing** – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The general term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**Daily cost-sharing rate** – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

**Deductible** – The amount you must pay for health care or prescriptions before our plan begins to pay.

**Disenroll or Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

**Grievance** - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Home Health Aide** – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

**Hospice** - An enrollee who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

**Income Related Monthly Adjustment Amount (IRMAA)** – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5 percent of people with Medicare are affected, so most people will not pay a higher premium.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your “out-of-pocket costs” for the year have reached \$4,850.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Institutional Special Needs Plan (SNP)** – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

**Institutional Equivalent Special Needs Plan (SNP)** – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

**Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

**List of Covered Drugs (Formulary or "Drug List")** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy (LIS)** – See "Extra Help."

**Maintenance Therapy** – Maintenance Therapy includes services that seek to prevent disease, promote health, prolong or enhance quality of life, or maintain or prevent deterioration of a chronic condition. Maintenance therapy is covered only when determined to be reasonable and effective under Medicare standards.

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state,

but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

**Medicare Advantage Disenrollment Period** – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2016.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Cost Plan** – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

**Organization Determination** – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the



deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost-sharing” above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's “out-of-pocket” cost requirement.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

**Part C** – see “Medicare Advantage (MA) Plan.”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

**Prosthetics and Orthotics** – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Providers** - Doctors and other health care professionals licensed by the state to provide medical services and care. Also includes hospitals and other health care facilities and providers of medical supplies and equipment.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Chapter 12. Definitions of important words**

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**Special Enrollment Period** – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Services** – Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

# Multi-Language Insert

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-559-3500. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-559-3500. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-559-3500。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-559-3500。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-800-559-3500. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-559-3500. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-559-3500 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-559-3500. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-559-3500번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-559-3500. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

### Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-800-559-3500. سيقوم شخص ما يتحدث العربية مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-559-3500 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-559-3500. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-559-3500. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-559-3500. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-559-3500. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-559-3500にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



**SCAN EMPLOYER GROUP MEMBER SERVICES**

METHOD	MEMBER SERVICES—CONTACT INFORMATION
<b>CALL</b>	<p><b>1-800-559-3500</b></p> <p>Calls to this number are free.</p> <p>Contact us October 1 to February 14: 8 A.M. to 8 P.M., 7 days a week.</p> <p>February 15 to September 30: 8 A.M. to 8 P.M., Monday through Friday, and 9 A.M. to 4 P.M. Saturday.</p> <p><b>Note:</b> We are closed on most federal holidays. When we are closed you have an option to leave a message. Messages received will be returned within 1 business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
<b>TTY</b>	<p><b>711</b></p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Contact us October 1 to February 14: 8 A.M. to 8 P.M., 7 days a week.</p> <p>February 15 to September 30: 8 A.M. to 8 P.M., Monday through Friday, and 9 A.M. to 4 P.M. Saturday.</p> <p>Messages received on holidays and outside of our business hours will be returned within one business day.</p>
<b>FAX</b>	<b>1-562-989-5181</b>
<b>WRITE</b>	<p><b>SCAN Health Plan</b></p> <p>Attention: Member Services Department</p> <p>P.O. Box 22616, Long Beach, CA 90801-5616</p> <p>MemberServices@scanhealthplan.com</p>
<b>WEBSITE</b>	<a href="http://www.scanhealthplan.com">www.scanhealthplan.com</a>

**Health Insurance Counseling and Advocacy Program (HICAP) (California's SHIP)**

Health Insurance Counseling and Advocacy Program (HICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

METHOD	CONTACT INFORMATION
<b>CALL</b>	<b>1-800-434-0222</b>
<b>WRITE</b>	<p><b>HICAP</b></p> <p><b>Los Angeles County:</b> 520 S. La Fayette Park Pl., Ste. 214, Los Angeles, CA 90057</p> <p><b>Orange County:</b> 1971 E. 4<sup>th</sup> St., Ste. 200, Santa Ana, CA 92705</p> <p><b>Riverside and San Bernardino Counties:</b> 9121 Haven Ave., Ste. 120, Rancho Cucamonga, CA 91730</p> <p><b>San Diego County:</b> 5151 Murphy Canyon Road, Ste. 110, San Diego, CA 92123</p> <p><b>Ventura County:</b> 646 County Square Dr., Ste. 100, Ventura, CA 93003</p> <p><b>Santa Clara County:</b> 2115 The Alameda, San Jose, CA 95126</p> <p><b>San Joaquin County:</b> 3950 Industrial Blvd., Ste. 500, West Sacramento, CA 95691</p> <p><b>Marin, Napa and Sonoma Counties:</b> 1304 Southpoint Blvd., Ste. 280, Petaluma, CA 94954</p> <p><b>San Francisco County:</b> 601 Jackson St., 2<sup>nd</sup> Floor, San Francisco, CA 94111</p>

**FIRST AMENDMENT TO RETIREEE GROUP HEALTH SERVICES AGREEMENT  
BETWEEN SCAN HEALTH PLAN AND COUNTY OF RIVERSIDE**

This First Amendment to the Retiree Group Health Services Agreement ("Amendment") is made and entered into by and between SCAN Health Plan ("Plan"), a California non-for-profit corporation, and the County of Riverside ("Contractholder"), a political subdivision of the State of California. This Amendment is effective as of January 1, 2017.

WHEREAS, the parties desire to renew the Retiree Group Health Services Agreement originally effective January 1, 2016 ("Agreement");

NOW, THEREFORE, in consideration of the mutual promises and covenants set forth herein, the parties agree as follows:

1. All capitalized terms used herein and not otherwise defined shall have the meaning set forth in the Agreement.

2. Section 5.1 of the Agreement is deleted in its entirety and replaced with the following:

"Effective January 1, 2017 through December 31, 2017, the premiums are as follows:

Retiree Only	\$273.82
Retiree & Spouse	\$547.64
Retiree, Spouse & Disabled Child	\$821.46"

3. Section 14.2 is added to the Agreement as follows:

"14.2 This Agreement shall renew for one successive year, commencing on January 1, 2017 and shall continue in effect through December 31, 2017, unless earlier terminated as provided in **ARTICLE XII CANCELLATION** herein."

4. Exhibit 2, Combined Evidence of Coverage and Disclosure Information (EOC), of the Agreement is deleted in its entirety and replaced with Exhibit 2-A, Combined Evidence of Coverage and Disclosure Information (EOC), which is attached hereto and incorporated herein by this reference.

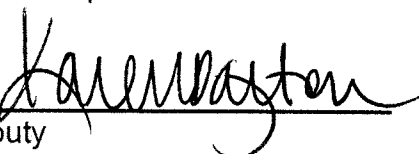
5. All other terms and conditions of the Agreement not modified herein shall remain unchanged.

6. Plan certifies that the individual signing herein has authority to execute this Amendment on behalf of Plan, and may legally bind Plan to the terms and conditions of this Amendment, including any attachments hereto.

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute this Amendment.

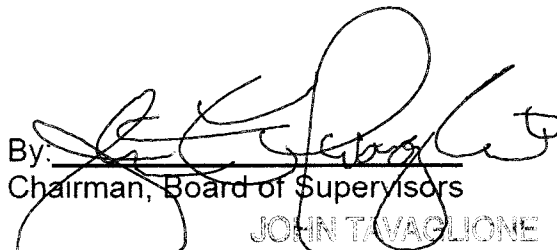
**ATTEST:**

Clerk of the Board  
Kecia Harper-Ihem

By:   
Deputy

Date: JUN 13 2017

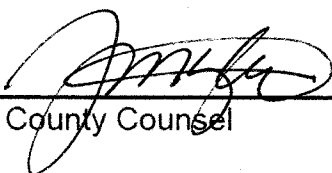
**COUNTY OF RIVERSIDE:**

By:   
Chairman, Board of Supervisors  
JOHN T. VAGLIONE

Date: JUN 13 2017

Approved as to Form:

Gregory P. Priamos  
County Counsel

By:   
Deputy County Counsel

**SCAN HEALTH PLAN,**  
a California not-for-profit corporation

By: 

Printed Name: Chris Wing

Title: Chief Executive Officer

Date: 5-17-17



**EXHIBIT 2-A**

**Combined Evidence of Coverage and Disclosure Information (EOC)**

**Effective as of January 1, 2017**



# 2017 Evidence of Coverage

## SCAN Employer Group (HMO)





January 1 – December 31, 2017

## Evidence of Coverage

### Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of SCAN Employer Group (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2017. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, SCAN Employer Group, is offered by SCAN Health Plan (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means SCAN Health Plan. When it says “plan” or “our plan,” it means SCAN Employer Group.)

SCAN Employer Group (HMO) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

This information is available for free in other languages.

Esta información está disponible gratuitamente en otros idiomas.

Please contact our Member Services number at 1-800-559-3500 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m. seven days a week from October 1 to February 14. From February 15 to September 30 hours are 8 a.m. to 8 p.m. Monday through Friday. Messages received on holidays and outside of business hours will be returned within one business day.

Comuníquese con nuestro Departamento de Servicios para Miembros al 1-800-559-3500 para obtener más información. (Los usuarios de TTY deben llamar al 711). El horario de atención es de 8 a.m. a 8 p.m., los siete días de la semana del 1 de octubre al 14 de febrero. Del 15 de febrero al 30 de septiembre el horario es de 8 a.m. a 8 p.m. de lunes a viernes. Los mensajes recibidos en días festivos o fuera de nuestras horas de oficina serán contestados dentro de un día hábil.

Member Services also has free language interpreter services available for non-English speakers (**phone numbers are printed on the back cover of this booklet**).

Servicios para Miembros también cuenta con personal y servicios gratuitos de interpretación (los números de teléfono están impresos en la portada posterior de este folleto).

We can also give you information for free in large print, Braille, audio recording, or other alternative formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2018.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Network is a group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

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