SummaCare Secure
A Medicare Advantage Plan

SummaCare Secure Appeals and Grievances Overview

(For SummaCare Secure Silver Plus (HMOPOS), Gold Plus (HMOPOS) and Platinum (HMOPOS) Plans)

CMS#H3660_10-51

SummaCare Secure Appeals and Grievances Overview

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Thank you for your interest in our SummaCare Secure Medicare Advantage plans.

Members of Medicare Advantage plans have the right to file formal complaints if they have problems or concerns relating to their medical or prescription drug coverage or care. These complaints can be Appeals or Grievances. This overview gives a general description of our Appeals and Grievance Process and explains the difference between the two types of complaints.

This is just an overview. For a complete description of our Appeals and Grievance Process, you can request a copy of the *Evidence of Coverage* by calling Customer Service at 1-800-996-6250 (TTY only, call 1-800-750-0750). Hours are 8 a.m. to 8 p.m. Monday through Friday. From November 15, 2009 through March 1, 2010, a representative will be available from 8 a.m. to 8 p.m. seven days a week and calls to these numbers are free. You can also visit our website, www.medicare.summacare.com.

What to do when you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service at the phone number listed above and we will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

There are two formal processes for dealing with problems:

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

To deal with your problem, which process should you use?

Is your problem or concern about whether particular medical services or prescription drug care are covered or not, the way in which they are covered, and problems related to payment for medical services or prescription drugs. If so, you will want to read the next section: "A guide to the basics of coverage decisions and making appeals."

If your problem or concern is related to quality of care, waiting times, and/or the customer service you receive you will want to read the section: "How to make a complaint."

COVERAGE DECISIONS AND APPEALS

A guide to the basics of coverage decisions and appeals

The process for coverage decisions and making 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.

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 prescription drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, 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.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the 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.

An **"appeal"** is a formal way of asking us to review and change a coverage decision we have made. If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

How to get help when you are requesting a coverage decision or making an appeal

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 Customer Service** (See section "Important Contact Information" for phone numbers).
- To get free help from an **independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program. (See section "Important Contact Information" for phone numbers.)
- **You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- **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 Customer Service (See section "Important Contact Information" for phone numbers) and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan 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.

How to ask for a coverage decision for medical care or services

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 decision."**

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 provide coverage for the medical care you want. You, or your doctor, or your representative can do this. You must submit your request within 60 calendar days of the date of the notice of the adverse organization determination. This 60 day timeframe can be extended for good cause.

Generally we use the standard deadlines for giving you our decision

A standard decision means we will give you an answer within 14 days after we receive your request.

- However, we can take up to 14 more days if you ask for more time, or if we need information (such as medical records) 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 (grievances), including fast complaints, see "Making a Complaint."

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 days after we received your request. If we extended the time needed to make our decision, we will 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.

If your health requires it, ask us to give you a "fast decision"

- A fast decision means we will answer within 72 hours after we receive your request.
  - However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need 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" (grievance) about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see "Making a Complaint".) We will call you as soon as we make the decision.

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 decision, we will 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 2: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If our plan says 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 "How to request an appeal" below).

How to request an appeal

Step 1: **You contact our plan 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 representative, or in some cases your doctor must contact our plan.**
- **Make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling Customer Service (See section "Important Contact Information" for phone numbers).
- **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.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
  - 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.

Generally we use standard deadlines for answering your 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 days.**
  - 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 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, we must authorize or provide the coverage we have agreed to provide within 30 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 sent your appeal to the Independent Review Organization for a Level 2 Appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request)

- If you are appealing a decision our plan 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."
- If your doctor tells us that your health requires a "fast appeal," we will automatically agree to give you 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 days.**
  - 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 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.

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 sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 2: **If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.**

- To make sure we were being fair when we said no to your appeal, **our plan is 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.

How to make a level 2 appeal

If our plan says 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 our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Step 1: **The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an outside, 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.
- 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 "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2*

- If you made a standard appeal to our plan at Level 1, 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 days**.

*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, 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 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 days after we receive the decision from the review organization.
- **If this organization says no to your appeal**, it means they agree with our plan that 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.")
    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with 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).

- The Level 3 Appeal is handled by an administrative law judge. 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. Your case must meet certain requirements to qualify for this level of appeal.
- The Level 4 appeal is handled by the Medicare Appeals Council. If either you or the plan is unhappy with the Level 3 decision either of us can ask for this review. Your case must meet certain requirements to qualify for this level of appeal.
- The Level 5 appeal is handled by the Federal District Court. If either you or the plan is unhappy with the Level 4 decision either of us can ask for this review. Your case must meet certain requirements to qualify for this level of appeal.

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

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **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.

Part D coverage decisions and appeals

A **"coverage decision"** is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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*
  - 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* but we require you to get approval from us before we will cover it for you.)
- 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 this guide to help you determine which part has information for your situation:

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan 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 plan's *List of Covered Drugs (Formulary).* (We call it the "Drug List" for short.)

    - 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 cost sharing tier three. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
    - You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover.

2. Removing a restriction on the plan's coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on the plan's *List of Covered Drugs*.

    - 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.
        - *Being required to try a different drug first* before we will agree to cover the drug you are asking for.
        - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
    - If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of four cost-sharing tiers.

   - If your drug is in Tier 3, the non preferred Brand Name Tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2, the preferred Brand Name Tier. 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 4, the Specialty drug tier.

How to ask for a Part D coverage decision, including an exception

Step 1: **You ask our plan 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 decision." You cannot ask for a fast 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 our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this.
- **If you want to ask our plan to pay you back for a drug,** send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement.

Generally we use standard deadlines for answering your request for a coverage decision

When we give you our decision, we will use the "standard" deadlines. A standard decision means we will give you an answer within **72 hours** after we receive your doctor's statement.

- 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 tell 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 we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** 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.

If your health requires it, ask us to give you a "fast 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 tell 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 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.

To get a fast decision, you must meet two requirements:

- You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
- You can get a fast 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 decision," we will automatically agree to give you a fast decision.

If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.

- If we decide that your medical condition does not meet the requirements for a fast 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 decision, we will automatically give a fast decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our 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, see the section titled "How to make a complaint".)

Step 2: If we say no to your coverage request, you decide if you want to make an appeal.

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

How to make a level 1 appeal

Step 1: You contact our plan 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 our plan.
- Make your appeal in writing by submitting a signed request. You may also ask for an appeal by calling us.
- 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.
- 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.

Generally, we will use the standard deadlines

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 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.

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.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan 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 decision".

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 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, we must provide the coverage we have agreed to provide within 72 hours.

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 our plan says 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).

How to make a level 2 appeal

If our plan says 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 our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Step 1: **To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If our plan says 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 outside, 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 review our decisions about your Part D benefits with our plan.
- 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.

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 s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

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.

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.")

To continue and 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 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 if the dollar value of the coverage you are requesting is high enough 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).
- 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. The details on how to do this are in the written notice you got after your Level 2 Appeal. Your case must meet certain requirements to qualify for this level of appeal.
  - The Level 4 appeal is handled by the Medicare Appeals Council. If either you or the plan is unhappy with the Level 3 decision either of us can ask for this review. Your case must meet certain requirements to qualify for this level of appeal.
  - The Level 5 appeal is handled by the Federal District Court. If either you or the plan is unhappy with the Level 4 decision either of us can ask for this review. Your case must meet certain requirements to qualify for this level of appeal.

Other types of appeals

In addition to appeals for your medical care and prescription drug coverage, there are also appeals for when you think your coverage is ending too soon for the following services:

- Inpatient Coverage
- Skilled Nursing Facilities
- Home Health Care
- Comprehensive Outpatient Rehabilitation Facility

For more information on how to file these types of appeals, contact Customer Service ((See section "Important Contact Information" for phone numbers) and request a copy of the *Evidence of Coverage.*

MAKING COMPLAINTS

How to make a complaint

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.

- **Quality of your medical care**: Are you unhappy with the quality of care you've received (including care in the hospital)?
- **Respecting your privacy**: Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**: Has someone been rude or disrespectful to you? Are you unhappy with how our Member Services has dealt with you? Do you feel you are being encouraged to leave our plan?
- **Waiting times**: Are you having trouble getting an appointment, or waiting too long to get it? Have you been kept waiting too long by doctors, pharmacists, or other health professional? Or by Member Services or other staff at our plan? Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.
- **Cleanliness**: Are you unhappy with the cleanliness or condition of a doctor's office, clinic, or hospital?
- **Information you get from our plan:** do you believe we have not given a notice that we're required to give? Do you think written information we have given you is hard to understand?

You can also file a complaint if you think we have not responded quickly enough:

- If you have asked our plan to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does 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.

Making a complaint

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

- **Usually, calling Customer Service** (See section "Important Contact Information" for phone numbers) **is the first step**. If there is anything else you need to do, Customer Service will let you know.
- **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 do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
    - You may file a written grievance by sending a letter, fax, or email to SummaCare describing your complaint. You may mail your grievance to SummaCare, P.O. Box 3620, Akron, OH 44309-3620 or send an email to www.summacare.com or fax us at 330-996-8545. If the grievance is about SummaCare's refusal to grant an enrollee's request for an expedited organization determination/coverage determination or appeal, then SummaCare will expedite the grievance and verbally respond within 24 hours.
    - The Grievance must be submitted within 60 day 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 days after receiving your complaint. We may extend the timeframe by up to 14 days if you ask for an extension, or if we justify a need for 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 Customer Service right away.** The complaint must be made within 60 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 response" to a coverage decision or 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**.

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 days, but we may take up to 44 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 days (44 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.

Making a complaint to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan 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 our plan). See section "Important Contact Information" for phone numbers.

- **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 our plan and also to the Quality Improvement Organization.

Important Contact Information

To contact:

SummaCare Secure regarding Customer Service, Coverage decisions for medical care or prescription drug coverage, payment requests or complaints: Call 1-800-996-6250 (TTY only, call 1-800-750-0750). Calls to this number are free.
We are available for phone calls 8 a.m. to 8 p.m. Monday through Friday. From November 15, 2009 to March 1, 2010, a representative will be available to speak to you from 8 a.m. through 8 p.m. seven days a week.

SummaCare Secure regarding Appeals: Call 1-330-996-8480 (TTY only, call 1-800-750-0750). Calls to this number are not free.

State Health Insurance Assistance Program, in Ohio this is the Ohio Senior Health Insurance Information Program: Call 1-800-686-1578. Calls to this number are free.

Quality Improvement Organization, in Ohio this organization is called KePro: Call 1-216-447-9604. Calls to this number are not free.