



CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

Plan's grievance, coverage/organization determination, and appeals processes.

What to do if you have a problem or concern

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 Member Services 1-800-204-1002 (TTY 711) 7-days-a-week, 8 a.m. to 8 p.m. 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.

Two processes for dealing with problems and concerns

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

There are two types of processes for handling problems and concerns:

- 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.

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.

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. 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.

- When a coverage decision involves your medical care, the initial determination is called an **"organization determination."**
 - **"Standard" Organization Determinations** are reviewed for medical necessity with a determination as to whether to provide or reimburse the care or service within 14 days of the request.
 - A **"fast decision" is called an "expedited determination". "Expedited" Organization Determinations** may be requested where adherence to standard deadlines could cause serious harm to your health or hurt your ability to function. You may also request a "fast decision" if you are asking for coverage for medical care you have not yet received. If your doctor tells us that your health requires a "fast decision" we will automatically agree to give you a fast decision.

An expedited organization determination must be processed and decision rendered within 3 calendar days.

Care Improvement Plus is a Medicare Advantage Plan with a Medicare contract.

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For an **organization determination** for medical care, call Member Services at 1-800-204-1002 (TTY 711) 7-days-a-week, 8 a.m. to 8 p.m., or write to Care Improvement Plus, Attn: Organization Determination, 351 W. Camden Street, Suite 100, Baltimore, MD 21201.

If we say no, you have the right to ask us to reconsider – or perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- When the coverage decision is about your Part D drugs, the initial determination is called a “**coverage determination.**” 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 Formulary
 - 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.

For a **coverage determination** for Part D drugs, please call Pharmacy Services at 1-800-753-2851 (TTY711) 24/7 or write Medco Health Solutions Attn: Medicare Reviews, P.O. Box 63067, Irvin, TX 75063-0118. Formulary exception requests can be made by calling Member Services at 1-800-204-1002 (TTY711) 7-days-a-week, 8 a.m. to 8 p.m..

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

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 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.

Making Complaints

If you are dissatisfied or have a complaint about any aspect of Care Improvement Plus, you may call or write our Member Services department. Complaints other than those involving organization determinations or coverage determinations are called grievances. (Complaints about denials and other adverse organization determinations or coverage determinations are handled as appeals, and are not grievances.) We will investigate the grievance and respond to you in a timely manner. Complaints about denied requests for an expedited decision or appeal, or disagreements over time extensions, will be handled as expedited grievances – they are reviewed and resolved within 24 hours.

Care Improvement Plus members: for more detailed information on coverage decisions, appeals and complaints, refer to Chapter 9 (*What to do if you have a problem or complaint*) of your Evidence of Coverage booklet.