Appeals and Grievances

Organization Determinations

When a coverage decision involves your medical care, it is called an "organization determination." 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 and/or your doctor 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 we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. 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.

If your health requires it, ask us to give you a "fast decision." A fast decision means we will answer within 72 hours. 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" about our decision to take extra days.

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

- You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
- 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 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 support, our plan will decide whether your health requires that we give you a fast decision.

Appeals

An "appeal" is the type of complaint you make when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Central Health Medicare Plan or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Central Health Medicare Plan or one of our plan providers reduces or cuts back on services or benefits you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service or benefit too soon, you can file an appeal.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review we give you our 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 our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal. For more information on Appeals, please see Chapter 9 of your Evidence of Coverage.

Grievances

A "grievance" is the type of complaint you make if you have any other type of problem with Central Health Medicare Plan or one of our plan providers. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach

someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services 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. The grievance must be submitted within 60 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 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the 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.

Member Services will send an acknowledgement letter to the member within 5working days of receipt of your written grievance. We will respond within 24hours to an expedited grievance when the Plan extends the time frame or decides not to conduct expedited organization/coverage determination or reconsiderations/redeterminations. Once the grievance is thoroughly investigated and resolved, a letter will be sent to the member within 5 calendar days of the date of resolution of the grievance.

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 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.

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 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.

You may request an organization determination, appeal and grievance:

- In writing, Central Health Medicare Plan, Member Services Department, 1540 Bridgegate Drive, Diamond Bar, CA 91765
- By fax, at (626) 388-2361
- By telephone – if it is a fast appeal – at (866) 314-2427 or TTY/TDD 711
- In person, Central Health Medicare Plan, Member Services Department, 1540 Bridgegate Drive, Diamond Bar, CA 91765

For quality of care complaints, you may also complain to Livanta, LLC(Livanta) the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the plan sponsor under the grievance process, by an independent organization called Livanta, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with Livanta in addition to or in lieu of a complaint filed under the plan sponsor's grievance process. For any complaint filed with Livanta, the plan sponsor must cooperate with the QIO in resolving the complaint. For more details on filing a complaint with Livanta, refer to the Evidence of Coverage (EOC)booklet.

For information on how to obtain a summary of information regarding the grievances, appeals, and exceptions filed against our plan, or if you have process or status questions, please contact customer service at 1-866-314-2427, TTY/TDD 711, from 8:00 AM to 8:00 PM, 7 days a week (PT).

Medicare Complaint Form

You may also file a complaint directly with Medicare by following the link below and completing a Medicare Complaint Form.

https://www.medicare.gov/medicarecomplaintform/home.aspx