BayCarePlus™

Medicare Advantage

Your Rights and Protections as a BayCarePlus Member

This booklet contains information about Organization & Coverage Determinations, Exceptions, Appeals and Grievances

BayCarePlus wants to be your partner in good health. In this role, we are always working to improve the quality of care and service that our members receive. This booklet explains our procedures concerning initial organization & coverage determinations, exceptions, appeals and grievances. We look forward to having you as a member of our plan.

COVERAGE DECISIONS & APPEALS

Many **BayCare**Plus members never experience a problem or have a complaint about their care, Part D benefits, payment for care or other related issues. If you experience such an issue while a member, rest assured that there are six possible steps you can take to ask for the care, benefits, or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care, benefits, or payment. The six possible steps are summarized below. Our Evidence of Coverage (EOC) provides additional information about each step. You will receive a copy of the EOC when you join a plan.

STEP 1: The Initial Decision or Coverage Determination by BayCarePlus

The starting point is when we make an "initial decision" about your medical care, Part D prescription drug, or about paying for medical care or a drug that you have already received. When we make an "initial decision," we are giving our interpretation of how the services and benefits that are covered for **BayCare**Plus members apply to your specific situation.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision deadline for medical care you requested is 14 days. For paying for medical care you already received, the deadline is 30 days after we receive your request. A standard decision for a Part D prescription drug or payment for a drug already received means we will give you an answer within 72 hours.

If your health requires it, you, your authorized representative, or your physician can ask for a "fast initial decision" if you have a request for medical care or Part D benefits that needs to be decided more quickly than the standard time frame. You can get a fast initial decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function. A fast initial decision for medical care means we will give you an answer within 72 hours after we receive your request. A fast initial decision for a Part D prescription drug means we will give you an answer within 24 hours.

STEP 2: Appealing the Initial Decision by BayCarePlus

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination." When our plan is reviewing your appeal, we take another careful look at all of the information about your request to decide whether to stay with our original decision, or change this decision and give you some or all of the care, benefit, or payment you want.

When we are using the standard appeal deadlines, we must give you our answer within 30 calendar days if your appeal is about medical coverage for services you have not received and 60 calendar days if your appeal is about services you have already received. When we are using the standard appeal deadlines for Part D prescription drugs, we must give you our answer within 7 calendar days. Your request must be made within 60 days of the initial decision. You or your authorized representative must file a standard appeal by mailing your request in writing within 60 days of the initial decision to:

BayCare Health Plans
Attn: Appeals
P.O. Box 3710
Troy, MI 48007

You, your authorized representative, or your physician can ask for a "fast appeal" if your request for medical care or Part D benefit needs to be decided more quickly than the standard time frame. When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. To file a "fast" appeal, you, your authorized representative, or your physician may call Customer Service at the number listed at the end of this document.

STEP 3: Review of your request by an Independent Review Organization

If we deny part or all of your request for medical care or payment for medical care in Step 2, we are required to send your request to an Independent Review Organization to ensure we were following all the rules when we denied 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 will review your request and make a decision about whether we must give you the care or payment you want. If we deny your request for a Part D prescription drug in Step 2, you may ask an Independent Review Organization to review our decision.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the Independent Review Organization in Step 3 and if the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to ask for an Administrative Law Judge to consider your case and make a decision. If the dollar value is less than the minimum level, you cannot appeal any further.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made by the Administrative Law Judge in Step 4, either of us may be able to ask the Medicare Appeals Council to review your case. The Medicare Appeals Council is part of the federal government.

STEP 6: Review by a judge at the Federal District Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a judge at the Federal District Court.

How do I request an exception to the BayCarePlus Formulary?

There are several types of exceptions that you can ask us to make to our coverage rules.

- You can ask us to cover your prescription drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, **BayCare**Plus limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Non-Preferred brand drug, you can ask us to cover it as a Preferred Brand instead. This would lower the copayment amount you must pay for your drug.

Generally, **BayCare**Plus will only approve your request for an exception if the alternative drug(s) included on the plan's formulary or the lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. Once an exception request is approved, it is valid for the remainder of the plan year as long as your physician continues to prescribe the drug for you and it continues to be safe and effective for treating your condition.

You, your representative, or your doctor can ask for an exception in the following ways:

- **Print form and mail:** Visit BayCarePlus.org online and select "Documents" in the navigation bar. Once on the Documents page, under "Downloadable Forms" select "Medicare Prescription Drug Coverage Determination Request Form." Print the form, complete, and mail to the address specified on the form.
- **Complete online:** Visit BayCarePlus.org online and select "Documents" in the navigation bar. Once on the Documents page, under "Downloadable Forms" select "**Secure Online Form - Request for Medicare Prescription Drug Coverage Determination Request Form." Complete the online form and submit.
- **Mail or fax a handwritten request:** You can also mail a handwritten request or fax a request to the address or fax number specified on the Medicare Prescription Drug Coverage Determination Request Form.

- **Call Customer Service:** Call the Customer Service Department and ask for help with making an exception request.

If you need assistance with any part of this process, please do not hesitate to call Customer Service.

DISCHARGED FROM A HOSPITAL TOO SOON

If 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. During your 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." Our plan's coverage of your hospital stay ends on this 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.

What information should I receive during my hospital stay?

During your hospital stay, you will be given a written notice called An Important Message from Medicare about Your Rights. Read this notice carefully and ask questions if you don't understand it. This notice explains:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor.
- Your right to be involved in any decisions about your hospital stay, and who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal a discharge decision.

Someone at the hospital (for example, a caseworker or nurse) must give this notice to you within two days after you are admitted. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean you agree that coverage should end – it only means that you received the notice. You should keep a copy of this signed notice so you have the necessary information about making an appeal if you need it.

What do I do if I think I'm being discharged too soon?

- You can talk to the hospital staff, your doctor, and **BayCare**Plus about your concerns.
- You also have the right to an appeal (review) of your case by a Quality Improvement Organization (QIO). 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.

Please note: **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**

- If you do this, you will not have to pay for the services you receive during the appeal (except for charges such as copayments and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for all of the costs for services you receive after that date.

How do I appeal my hospital discharge?

If you think you are being discharged too soon and want to have your discharge reviewed, you must act quickly to contact the QIO. The Important Message from Medicare gives the name and telephone number of your QIO and tells you what you must do. You must ask the QIO for a "fast review" of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.

What happens during the QIO review process?

When the QIO reviews your case, the QIO will ask you, or your representative, why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue. After reviewing all the information, the QIO will make the decision within one full day after it receives the information it needs.

Who is responsible for payment during the review process?

If the QIO decides that your discharge date was not medically appropriate, then we will continue to cover your hospital covered services for as long as medically necessary. If the QIO decides that your discharge date was medically appropriate, our coverage for your hospital services will end at noon on the day after the QIO gives you its decision. If you decide to stay in the hospital after our coverage has ended, you may have to pay all of the costs for hospital care you receive after this date. If the QIO has denied your appeal, and you stay in the hospital after your planned discharge date, then you may continue the appeals process. Our Evidence of Coverage provides additional information about each appeal step.

Who is responsible for payment if I miss the QIO deadline and stay past my discharge date?

If you stay in the hospital after your planned discharge date and do not ask for immediate QIO review, 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 QIO, you can make an appeal to us by following the "fast" appeal procedures previously described in this document.
Who is responsible for payment during a "fast" appeal conducted by the plan?
Whether or not you have to pay depends on the decision we make.

- If we decide, based on the clinical information received from the hospital and your doctors, that your discharge date was not medically appropriate, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that your discharge date was medically appropriate, we will not cover any hospital care you received if you stayed in the hospital after your discharge date. If we uphold our original decision, we will automatically forward your case to the Independent Review Entity (IRE) within 24 hours.

TERMINATION OF SERVICES (SNF, CORF, HHA)

What information should I receive during my Skilled Nursing Facility stay, or while receiving CORF or HHA services?

If we decide to end coverage for your Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Home Health Agency (HHA) services, you will receive a written advance notice called the "Notice of Medicare Non-Coverage" (NOMNC) either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice. You should keep a copy of this signed notice so you have the necessary information about making an appeal if you need it.

How do I appeal the termination of SNF, CORF or HHA services?

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the QIO to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do I have to ask the QIO to review my coverage?

If you want to appeal the termination of your coverage, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of the QIO and tells you what

you must do. If you miss the deadline for contacting the QIO, you can make an appeal to us by following the "fast" appeal procedures previously listed in this document. You must make your request no later than noon the day before the date that your coverage ends.

What happens during the QIO review process?

When the QIO reviews your case, the QIO will ask you, or your representative, why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue. After reviewing all the information, the QIO will make the decision within one full day after it receives the information it needs.

Who is responsible for payment during the review process?

If the QIO decides that our decision to terminate coverage was not medically appropriate, we will continue to provide your covered services for as long as it is medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, your coverage will end on the date we have told you. If you decide to continue getting home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility services after this date when your coverage ends, you will have to pay the full cost of this care yourself. If the QIO has denied your appeal, and you continue getting care after your coverage for the care has ended, you may continue the appeals process. Our Evidence of Coverage provides additional information about each appeal step.

Who is responsible for payment if I miss the QIO deadline and continue receiving services?

If you continue getting services after your coverage end date and do not ask for immediate QIO review, you will have to pay the full cost of this care yourself. If you miss the deadline for contacting the QIO, you can make an appeal to us by following the "fast" appeal procedures previously listed in this document.
Who is responsible for payment during a "fast" appeal conducted by the plan?
Whether you have to pay or not depends on the decision we make.

- If we decide, based on the clinical information, that our decision to terminate coverage was not medically appropriate, we will continue to provide your covered services for as long as it is medically necessary.
- If we decide that our decision to terminate coverage was medically appropriate, your coverage will end on the date we have told you and we will not pay after this date. If we uphold our original decision, we will automatically forward your case to the Independent Review Entity (IRE) within 24 hours.

MAKING COMPLAINTS

You have the right to make a complaint if you have concerns or problems related to your medical coverage or care. If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you must use the process for coverage decisions and appeals that was explained earlier in this document. This section explains how to use the process for making complaints. The complaint process is used only for certain types of problems. 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.

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) **BayCare**Plus.
- Problems with the Customer Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.

- Problems with getting appointments when you need them, or having to wait a long time for an appointment or to have your prescription filled.
- Disrespectful or rude behavior by pharmacists, doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of pharmacies, doctor's offices, clinics, or hospitals.

We hope you never experience any of these problems. If you do, and you want to make a complaint, the act is called, "filing a grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal.

What do I do if I have a complaint?

We will try to resolve any questions or concerns that you might have over the phone. Based on the nature of the complaint, it may be addressed as a plan grievance or through the appeals process.

How do I file a grievance?

Your grievance must be submitted within 60 days of the event or incident. You may contact our Customer Service Department to express your grievance. If you do not wish to call or you called and were not satisfied, you may send your grievance in writing to:

BayCare Health Plans
Attn: Grievances
P.O. Box 3710
Troy, MI 48007

What happens during the grievance process?

BayCarePlus takes this type of information very seriously. We will investigate the matter thoroughly and take action if necessary.

When will BayCarePlus respond to me with a decision about my grievance?

We must notify you of our decision about 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 request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the Quality Improvement Organization.

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to the Quality Improvement Organization (QIO). The QIO 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 get information on how to contact the QIO, refer to your EOC (Evidence of Coverage). If you file a quality of care grievance with us, our decision letter will also include information on how to contact the QIO.

What if I want to designate someone to represent me during an appeal or grievance?

At any time during the grievance or appeal process, you may authorize a representative to assist you in the process. We must receive an authorization, in writing, from you to designate a representative. You can contact our Customer Service department for additional information about designating a representative or complete the AOR form online located at BayCarePlus.org under "Documents."

BayCare Plus™
Medicare Advantage

Customer Service Contact
Information for BayCarePlus Medicare Advantage

(866) 509-5396
TTY 711
8 am to 8 pm, 7 days a week*

*You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day.

BayCare Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Health Plans depends on contract renewal.