**Medical Care, Services, and Payment - Determinations, Appeals, and Grievances**

The section provides a brief summary of your rights to request coverage of medical care, or services or payment for medical services that you already have received. You may also make a complaint about your medical benefits and coverage. Your Evidence of Coverage explains the grievance and appeals rights and procedures in more detail.

**Introduction**

- A coverage decision is often called an initial determination or initial decision. When a coverage decision involves your medical care, it is called an "organization determination." An organization determination has been made when a decision about whether services are covered or how much you have to pay for covered services. If our initial decision is to deny your request, you can appeal the decision by going to Appeal Level 1 (below).

- An "appeal" is something you do if you disagree with a decision to deny a request for 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 a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive.

- A "grievance" is the type of complaint that you make about us or our network providers or pharmacies, including a complaint concerning the quality of your care. This type of compliant does not involve coverage or payment disputes. For example, you would file a grievance if you have a problem such as the quality of your care, waiting times for appointments, the way your doctors or others behave, or the cleanliness or condition of a doctor's office.

**Organization Determination** (Referral, Prior Authorization, and Payment requests for medical services)

Note: Approval is not required for emergency or urgently needed care that you get for an out-of-network provider. Please go to the nearest hospital emergency room or urgent care center. Emergency care should not be delayed!

**Referral and Prior Authorization**:
We do not require a referral from your primary care physician to see network providers or network specialists; however, some services may require prior authorization from your physician. For a list of services which require prior authorization, click here. You can also refer to Chapter 4 in your plan specific Evidence of Coverage for a list of services that are covered for you and authorization rules that may apply.

If you need Medicare covered services, and the providers in our network cannot provide this service, you may be able to receive the service from an out-of-network provider; however, prior authorization must be obtained from us prior to seeking services from the out-of-network provider. For more information on how to get care from an out-of-network provider, please refer to Chapter 3 in your plan specific Evidence of Coverage.

**How to Submit a Request**
You, your authorized representative, doctor or other medical provider may ask us whether we will approve medical services or treatment. A decision can be a standard decision that is made within the standard timeframe, or it can be a fast decision that is made more quickly. You can ask for a "fast" decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

To ask for an organization determination, call, write, or fax out plan to make your request. You, or your doctor, or your authorized representative can do this. Be sure to ask for a fast decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

**Telephone:**
For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 or, for TTY users, 330-363-7460 or 1-800-617-7446, Monday through Friday 8:00 a.m. to 8:00 p.m. (October 1 – February 14th, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)

**Fax:** 330-363-2350

**Mail:**
PrimeTime Health Plan Attention
Utilization Management
P.O. Box 6905
Canton, Ohio 44706

**Appeals (Medical Care)**
If we deny all or any part of your request in our organization determination, you have the right to ask us to reconsider this decision by making an appeal. 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.

**Types of Appeals**

**Fast Appeal** – You can ask for a fast appeal if your health requires it (you can make an oral request). 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. 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 decide to take extra days to make the decision, we will tell you in writing.

If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within the standard appeal timeframe.

**Standard Appeal** (Request for Service) - You can ask for a standard appeal requesting that we authorize or approve a service that you have not yet received. We must give you a decision no later than 30 days after we get your appeal. (If you ask for more time, or if we need to gather more information that may benefits you, we can take up to 14 more calendar days.)

**Standard Appeal** (Request for Payment) - You can ask for a standard appeal in writing requesting payment for a service you have already received. We must give you a decision no later than 60 days after we get your appeal.

**What Do I Include With My Appeal?**
You should include your name, address, member ID number, reasons for appealing, and any evidence that you wish to attach. You may include dates of service, claims numbers, supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal.

**How Do I File An Appeal?**

For a **Fast** Appeal: You, your doctor, or your authorized representative should contact us by telephone or fax:

**Telephone:**
For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 or, for TTY users, 330-363-7460 or 1-800-617-7446, Monday through Friday 8:00 a.m. to 8:00 p.m. (October 1 – February 14th, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)

**Fax:** 330-363-3066

For a **Standard** Appeal: You, your doctor, or your authorized representative should send your written request to:

PrimeTime Health Plan
Attention: Grievances/Appeals
P.O. Box 6029
Canton, Ohio 44706
Fax: 330-363-3066

**What Happens Next**?
If you appeal, we will review our decision. If we continue to deny any of the services that you requested, Medicare will provide you with a new and impartial review of your case by a reviewer outside of PrimeTime Health Plan. If you disagree with the decision of the outside reviewer, you may have further appeal rights. You will be notified of those appeal rights if this happens.

**You may check on the status of your appeal anytime by contacting Customer Service at the telephone number listed above.**

**<u>Grievances</u>**

**There are Two Kinds of Grievances That You Can Request**
**Fast** (24 hours) - If you disagree with our decision not to give you a fast decision on medical care, or if you disagree with our decision to take a time extension on initial decisions or appeals. We must respond to this type of grievance within 24 hours of the time that we receive it.

**Standard** - Any other type of complaint. 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 to14 more days if we need more information and the delay is in your best interest or if you ask for more time.

**How Do I Submit a Grievance?**
Usually, calling Customer Service 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 or your authorized representative can put your complaint in writing and send it to us. You or your authorized representative should call, fax, or mail your grievance request to the address/number below:

**You may check on the status of your grievance anytime by contacting Customer Service at the telephone number listed below.**

**Telephone:**
For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 or, for TTY users, 330-363-7460 or 1-800-617-7446, Monday through Friday 8:00 a.m. to 8:00 p.m. (October 1 – February 14th, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)

**Fax:** 330-363-3066

**Mail:**
PrimeTime Health Plan
Attention: Grievances/Appeals
P.O. Box 6029
Canton, Ohio 44706

**Contact Information**
If you need information or help, or would like to obtain an aggregate number of grievances and appeals filed with this plan, call us at:

**Telephone:**
For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 or, for TTY users, 330-363-7460 or 1-800-617-7446, Monday through Friday 8:00 a.m. to 8:00 p.m. (October 1 – February 14th, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)