Mary Washington
Medicare Advantage

Your Rights and Protections as a Member of Mary Washington Medicare Advantage

Information about Organization & Coverage Determinations, Appeals and Grievances, Exceptions

You may refer to Chapter 9 of your *Evidence of Coverage* (EOC) for more information on any of these topics. You received a copy of the EOC when you joined your Mary Washington Medicare Advantage plan, and you can also find it on this website. Our Customer Service Department can be reached by calling 844.529.3760 (TTY: 711).

COVERAGE DECISIONS & APPEALS

An organizational coverage decision is a decision Mary Washington Medicare Advantage makes about your benefits and coverage or about the amount we will pay for your medical services or drugs. You may ask for medical care and prescription drug coverage by contacting our Customer Service Department. Requests for reimbursement for services or drugs you have already received and paid for must be submitted in writing. We use the "standard" deadline for our decisions, unless we have agreed to use the "fast" deadlines. You can ask for a "fast" initial decision if your request for medical care or Part D drug benefits drug benefits needs to be decided more quickly than within the standard time frame.

Initial Request for Service or Benefit	Standard Decision Deadline	Fast Decision Deadline
Medical Request	Up to 14 days after receipt	Within 72 hours after receipt
Medical Care Already Received	Up to 60 days after receipt	N/A
Drug Covered by Part B or Part D	Up to 72 hours after receipt	Within 24 hours after receipt
Part D Drug Already Received	Up to 14 days after receipt	N/A

If you disagree with our coverage decision, you can make an appeal, asking us to review our decision. We will 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 request. Your appeal request must be made within 60 days of the initial decision.

You can ask for a "fast appeal" if your request for medical care or Part D drug benefits needs to be decided more quickly than within the standard time frame.

Appeal Type	Must be Filed By	Your Filing Deadline	Our Decision Deadline
Standard - Medical Care Request	Mail or Fax	Within 60 days of initial decision	Up to 30 days after receipt
Standard - Medical Care Already Received	Mail or Fax	Within 60 days of initial decision	Up to 60 days after receipt
Standard - Drug Covered by Part B or Part D	Mail or Fax	Within 60 days of initial decision	Up to 7 days after receipt
Fast - Medical Care Request or Drug Covered by Part B or Part D	Phone, Mail or Fax	Within 60 days of initial decision	Up to 72 hours after receipt

You may submit your appeal online or by mail, fax or phone to:

Mary Washington
Medicare Advantage

Standard Appeal

Mail: Mary Washington Medicare Advantage
Attn: Appeals
PO Box 7118
Troy, MI 48007

Fax: 844.335.3777

Fast Appeal

Phone: 844.529.3760

If we deny your appeal request, an Independent Review Organization will review your request for medical care (Part C) and Part B benefits. You may ask for an independent review of a Part D drug benefit decision.

Part C Medical and Part B Drugs:	Part D Drug: Standard Mail	Part D Drug: Courier (such as FedEx or UPS)
MAXIMUS Federal Services, Inc. Medicare Managed Care & PACE 3750 Monroe Ave., Suite 702 Pittsford, NY 14534-1302	C2C Innovative Solutions, Inc. Part D Drug Reconsiderations P.O. Box 44166 Jacksonville, FL 32231-4166	C2C Innovative Solutions, Inc. Part D Drug Reconsiderations 301 W. Bay St., Suite 600 Jacksonville, FL 32202

If you are unhappy with the decision made by the Independent Review Organization and the dollar value of appeal meets a minimum level, you may be able to ask for an Administrative Law Judge to consider your case. Additional reviews may be available by the Medicare Appeals Council and the Federal District Court.

ASKING FOR AN EXCEPTION TO THE DRUG FORMULARY

You can ask for an exception to the coverage rules of our drug formulary on the "Medicare Prescription Drug Coverage Determination Request Form." This form is available online. You can complete and submit the form online, or you can download the form and mail it to the address on the form. You can also mail or fax a request to the address or fax number specified on the Medicare Prescription Drug Coverage Determination Request Form.

Generally, Mary Washington Medicare Advantage 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.

DISCHARGED FROM A HOSPITAL TOO SOON

The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date. 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. If you want to appeal, you must contact the Quality Improvement Organization (QIO) no later than your planned discharge date and before you leave the hospital.

If you think you are being discharged too soon and want to have your discharge reviewed, you must contact the QIO:

Mary Washington
Medicare Advantage

Mail: Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701

Phone: 888.396.4646 (TTY: 888.985.2660)
Fax: 855.236.2423

TERMINATION OF SERVICES (SNF, CORF, HHA)

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 two calendar days before your coverage ends. 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. Use the contact information shown above to reach the QIO.

GRIEVANCES (Complaints)

We are committed to learning from our members' experience. Your perspective is essential in helping us ensure our members receive the highest quality of service and care.

When can I file a grievance?
If you are dissatisfied with any aspect of your plan, you have the right to file a grievance (complaint). This could include concerns with:

- plan benefit design
- lack of quality of the care received
- interpersonal aspects of care
- waiting times
- difficulty contacting the plan via phone
- information you get from us
- poor customer service or other negative behaviors

We encourage you to contact us promptly to report the event or incident.

If you are dissatisfied with a coverage or payment decision or want to dispute a decision, please reference the Appeals process.

How promptly should I submit my grievance?
Your grievance should be submitted within 60 days of the event or incident to ensure that we can promptly investigate any concerns.

Who can submit a grievance?
You or a person you appoint can submit a grievance. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the "Appointment of Representative" form (CMS-1696 form). This form is also available on our website. The form gives that person permission to file a grievance on your behalf. It must be signed by you and by the person who you would like to act on your behalf, and the plan must have a copy of the form.

Alternatively, you can submit an equivalent written notice instead of the "Appointment of Representative" form as long as the written notice is signed and dated by both you and your representative and includes the following information:

- Name, address, and telephone numbers of both parties
- Member's Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) found on your Red, White, and Blue Medicare Card, OR Member ID number found on your ID card
- Your status or relationship to the member
- A written explanation of the purpose and scope of the representation
- A statement that the member authorizes you to act on their behalf for the grievance, and a statement authorizing disclosure of individually identifying information to you
- A statement indicating you accept the member's appointment

Other documentation that indicates an individual is appointed to act on your behalf may include a durable power of attorney or court issued or legally binding documentation that states an individual is appointed by a court under state or other applicable law to act on your behalf.

How can I submit a grievance?
If you would like to submit a grievance, you can choose to:

- Call Customer Service
- Send your grievance in writing to: Mary Washington Medicare Advantage

  Attn: Grievances
  P.O. Box 7118
  Troy, MI 48007

If you choose to submit a written grievance, please ensure to include the following information to assist us in processing the complaint:

- Your first and last name
- Member ID number
- All pertinent information, including a summary of the complaint, any previous contact with us related to the complaint, and any supporting documents you believe are appropriate
- What you are asking us to do
- A signature from you or your authorized representative and the date

What happens next?
We will look into your complaint and give you our answer.

If possible, we will answer you right away. If you call us with the complaint, we may be able to give you an answer on the same phone call.

Most grievances are answered within 30 calendar days. If we need more information and the delay is in your best interest or you as for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

If you are interested in an expedited grievance review because the plan declined your request for an expedited initial organizational determination or appeal, we will provide a response within 24 hours.

CUSTOMER SERVICE

Mary Washington Medicare Advantage 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. For more information about any of these topics, please refer to your *Evidence of Coverage*, available on this

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website or by calling Customer Service at 844.529.3760 (TTY: 711), 8 a.m. to 8 p.m., seven days a week.

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