Important Plan Information for Signature Advantage (HMO SNP)

Member Services Contact Information:

Address: 12201 Bluegrass Parkway Louisville, KY 40299
Webpage: www.signatureadvantageplan.com
Fax number: 1-800-880-3263
Toll-free number: 1-844-214-8633 TTY users call 711
Hours of Operation: 8:00 a.m. to 8:00 p.m. (7 days a week from October 1 through March 31, except for holidays. Monday to Friday from April 1 through September 30, except for holidays).

Before Filing, Learn More about Out of Network Coverage Rules
As a member of our Plan, you must use Contracting Network Medical Providers. If you receive unauthorized care from an out-of-network provider, our Plan may deny coverage and you will be responsible for the entire cost. Here are three exceptions:

- Our Plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to learn what emergency or urgently needed care means, please contact Member Services.

- If you need medical care that 1) Medicare requires our Plan to cover, and 2) the Contracting Network Medical Provider cannot provide this care, you can get this care from an out-of-network provider. Prior Authorization should be obtained from our Plan prior to seeking care. In this situation, if the care is approved, you would pay the same as you would pay if you got the care from a Contracting Network Medical Provider. Your PCP or other Contracting Network Medical Provider, will contact our Plan to obtain authorization for you to see an out-of-network provider.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside of our Plan's service area. In these special circumstances, it is best to ask an out-of-network provider to bill us first. If you have already paid for the covered

services or if the out-of-network provider sends you a bill that you believe our Plan should pay, please contact Member Services or send us the bill.

Organization Determination, Coverage Determination, Grievance & Appeals Process

The following procedures for organization determinations, coverage determinations grievances, and appeals must be followed by our Plan in identifying, tracking, resolving and reporting all activity related to a(n) organization determination, coverage determination, grievance and/or appeal. This is only a brief summary. Please refer to your Evidence of Coverage for more details.

How to File a (Part C) Organization Determination?

What is an Organization Determination?
An organization determination is any decision (i.e., an approval or denial) made by our Plan regarding:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by our Plan.
- Refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by our Plan.
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
- Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Who Can Request an Organization Determination?
An enrollee, an enrollee's representative, or any provider that furnishes, or intends to furnish, services to an enrollee, may request a standard organization determination by filing an oral or written request to our Plan. Expedited (fast) requests may be requested by an enrollee, an enrollee's representative, or any physician, regardless of whether the physician is affiliated with our Plan.

When Can an Organization Determination Be Requested?
In circumstances where there is a question whether or not the plan will cover an item or service, you, your representative, or a provider on behalf of you, have the right to request a pre-service organization determination (prior authorization) from the plan.

Where Can an Organization Determination be filed?
Coverage requests can be filed by calling our Member Services Department at 844-214-8633 (TTY dial 711), 8am – 8pm 7 days per week from October 1 – March 31; and 8am – 8pm Monday – Friday from April 1 – September 30. Calls to this number or free.

The table below shows the timeframes the Plan must notify you of its coverage decision including whether item or service is medically necessary.

Review Request Type	Plan's Notification Timeframe
Standard/non-urgent pre-service medical services	Within 14 calendar days of the request
Standard/Non-urgent pre-service Part B drug services	Within 72 hours of the request
Expedited/Urgent pre-service medical services	Within 72 hours of the request
Expedited/Urgent pre-service Part B drug services	Within 24 hours of the request
Post-service/Payment	Within 30 calendar days of the request

You may file a reconsideration (appeal) if you disagree with the Plan's decision.

What Is a Standard Reconsideration (i.e., Appeal)?
A reconsideration is also known as an appeal. If our Plan denies an enrollee's request for an item or service in whole or in part (issues an adverse organization determination), the enrollee may appeal the decision to the plan by requesting a reconsideration.

A reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by our Plan.

Who can Request a Standard Reconsideration (i.e., Appeal)?

- An enrollee or an enrollee's representative may request a standard or expedited reconsideration (i.e., appeal).

- An enrollee's physician may request an expedited or a standard reconsideration without being appointed as the enrollee's representative, on the enrollee's behalf. If a physician requests the expedited reconsideration, our Plan is required to expedite the request.

How to Request a Reconsideration

- Reconsideration requests must be filed with our Plan within 60 calendar days from the date of the notice of the organization determination.
- Expedited requests can be made either orally or in writing.
- Standard requests must be made in writing unless the enrollee's plan accepts oral requests. An enrollee should call Member Services or check the Evidence of Coverage to determine if our Plan accepts oral standard requests.

Important Things to Know About Asking for Standard Reconsideration:

A party must file the request for reconsideration within sixty (60) calendar days from the date of the notice of the organization determination. If a request for reconsideration is filed beyond the sixty (60) calendar day time frame and good cause for late filing is not provided, our Plan will forward the request to the independent review entity (IRE) for dismissal.

Upon receipt of a request, our Plan must make its decision and notify the enrollee of its decision as quickly as the enrollee's health requires, but no later than 72 hours for expedited requests or 30 calendar days for standard requests, or 60 calendar days for payment requests.

Our Plan can accept or deny your request.

If we approve your request for a standard reconsideration, our Plan's approval is valid until the end of the plan year.

Where Can a Reconsideration Be Filed?

You or your representative can request a reconsideration by writing directly to us at Signature Advantage – Appeals and Grievances Department, 12201 Bluegrass Parkway Louisville, KY 40299 faxing us at 1-800-880-3263 or contacting Member Services Department at our toll-free number 1-844-214-8633, TTY users call 711. Hours of operations: 8:00 a.m. to 8:00 p.m. (7 days a week from October 1 through March 31, except for holidays. Monday to Friday from April 1 through September 30, except for holidays).

What is a Good Cause Exception?

If a party shows good cause, our Plan may extend the time frame for filing a request for reconsideration (i.e., appeal). We will consider the circumstance that kept the enrollee or representative from making the request on time and whether any organizational actions might have misled the enrollee.

Examples of circumstances where good cause may exist to file a late appeal include (but are not limited to) the following situations:

- The enrollee did not personally receive the adverse organization determination notice, or

he/she received it late;

- The enrollee was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the enrollee's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

How to File a (Part D) Coverage Determination?

What Is a Coverage Determination?

A coverage determination is decision made by our Plan (not the pharmacy) about your prescription drug benefits, including whether a particular drug is covered, whether you have met all the requirements for getting a requested drug, how much you're required to pay for a drug, and whether to make an exception to a Plan rule when you request it.

What Is an Exception?

If a drug is not covered on our Plan, you can ask our Plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if our Plan turns down your request for an exception, you can appeal our Plan's decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request.

Who Can Request a Coverage Determination / Exception?

A coverage determination may be requested by any of the following:

- You or your representative may request a coverage determination.
- Your prescriber (your doctor or other health care provider who is legallyallowed to write prescriptions) can request a coverage determination for you on your behalf.

When Can a Coverage Determination/ Exception Be Requested?

A coverage determination may be requested for any of the following:

- Covering a Part D drug for you that is not on our plan's List of CoveredDrugs

(Formulary).

- You may ask our plan for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your drug plan's list of covered drugs.
- You may ask for an exception if your network pharmacy can't fill a prescription as written.

- Removing a restriction on the plan's coverage for a covered drug.
  - You may ask for an exception if you or your prescriber believe that a coverage rule (such as a prior authorization) should be waived.

- Changing coverage of a drug to a lower cost-sharing tier. (Tier Exception)
  - You may ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believe you can't take any of the lower tier drugs for the same condition.

- Request for payment.
  - You may ask us to pay for a prescription that you already paid for.

Important Things to Know About Asking for Exceptions:

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include medical information from your doctor or other prescriber when you ask for the exception.

Our Plan can accept or deny your request.

If we approve your request for an exception, the approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request for an exception, you can ask us to review the decision by making an appeal. If your health requires a quick response, you must ask us to make a "fast decision".

Where Can an Exception Be Filed?

You or your representative can request an exception by writing directly to us at Signature Advantage – Appeals and Grievances Department, 12201 Bluegrass Parkway Louisville, KY 40299, faxing us at 1-800-880-3263 or calling Member Services at our toll-free number 1-844-214-8633, TTY users call 711. Hours of operations: 8:00 a.m. to 8:00 p.m. (7 days a week from October 1 through March 31, except for holidays. Monday to Friday from April 1 through September 30, except for holidays).

Your provider may also request an exception or expedited exception by contacting the Pharmacy

Help Desk at 1-833-803-4397, TTY users call 711, 24 hours a day/ 7 days a week.

Our Plan has seventy-two (72) hours (for a standard request) or twenty-four (24) hours for an expedited request) from the date your request is received to notify you of our Plan's decision.

How to File a Grievance/Complaint

What Is a Grievance?
A grievance is a type of complaint that does not involve payment or denial of services by our Plan or a Contracting Network Medical Provider.

For example, you would file a grievance if:

- You have a problem with things such as the quality of your care during a hospital stay;
- You feel you are being encouraged to leave our Plan;
- Waiting times on the phone, at a network pharmacy, in a provider's waiting room or exam room;
- Waiting too long for prescriptions to be filled;
- The way your doctors, network pharmacists or others behave;
- Not being able to reach someone by phone or obtain the information you need; or
- Lack of cleanliness or the condition of the office.

Who Can File a Grievance?
A grievance may be filed by any of the following:

- You may file a grievance.
- Someone else may file the grievance for you on your behalf.

You may appoint an individual to act as your representative to file the grievance for you by following the steps below:

1. Provide our Plan with your name, your Member ID number, your Medicare number and a statement which appoints an individual as your representative. (Note: You may appoint a physician or a Provider.) For example: "I [your name] appoint [name of representative] to act as my representative in filing a grievance."
2. Provide your name, address and phone number and that of your representative, if applicable.
3. You must sign and date the statement.
4. Your representative must also sign and date this statement.
5. You must include this signed statement with your grievance.

Why File a Grievance?
You are encouraged to use the grievance procedure when you have any type of complaint (other than an appeal) with our Plan or a Contracting Network Medical Provider, especially if such complaints result from misinformation, misunderstanding, or lack of information.

When Can a Grievance Be Filed?
You may file a grievance within sixty (60) calendar days of the date of the circumstance giving rise to the grievance. There is no filing limit for complaints concerning quality of care. Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day time frame.

Can I Expedite a Grievance?
You have the right to request a fast review or expedited grievance if you disagree with our Plan's decision to invoke an extension on your request for an organization determination or reconsideration, or our Plan's decision to process your expedited request as a standard request. In such cases, our Plan will acknowledge your grievance within twenty-four (24) hours of receipt and notify you in writing of our Plan's conclusion within three (3) calendar days.

Where can a Grievance Be Filed?
You may file a standard grievance in writing directly to: Signature Advantage -Appeals and Grievances Department, 12201 Bluegrass Parkway Louisville, KY 40299.

You may file a standard or expedited grievance by fax to 1-800-880-3263 or by calling Member Services at our toll-free number 1-844-214-8633, TTY users call 711. Hours of operations: 8:00 a.m. to 8:00 p.m. (7 days a week from October 1 through March 31, except for holidays. Monday to Friday from April 1 through September 30, except for holidays).

If you would like you can file a complaint directly to Medicare by filling out the complaint form by calling 1-800-MEDICARE at http://www.medicare.gov/claims-and-appeals/file-a-complaint/health-or-drug-plan/complaints-about-plans.html.

How to File an Appeal

What Is an Appeal?
An appeal is a type of complaint you make when you want our Plan to review a decision that was made regarding coverage of a service, the amount our Plan paid for a service, the amount our Plan will pay for a service, or the amount you must pay for a service.

For example, you may file an appeal for any of the following reasons:

- Our Plan refuses to cover or pay for services you think our Plan should cover.
- Our Plan or one of the Contracting Network Medical Providers refuses to give you a service

you think should be covered.

- Our Plan or one of the Contracting Network Medical Providers reduces or cuts back on services you have been receiving.
- If you think that our Plan is stopping your coverage too soon.
- Complaints concerning organization determinations are resolved through appeal procedures.

Why File an Appeal?

You may use the appeal procedure when you want a reconsideration of a decision (organization determination) that was made regarding a service or the amount of payment our Plan paid for a service.

Who Can File an Appeal?

An appeal may be filed by any of the following:

- You may file an appeal.
- Someone else may file the appeal for you on your behalf.

You may appoint an individual to act as your representative to file the appeal for you by following the steps below:

1. Provide our Plan with your name, your Member ID number, your Medicare number and a statement which appoints an individual as your representative. (Note: You may appoint a physician or a Provider.) For example: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal from Signature Advantage and/or CMS regarding the denial or discontinuation of medical services."
2. Provide your name, address and phone number and that of your representative, if applicable.
3. You must sign and date the statement.
4. Your representative must also sign and date this statement.
5. You must include this signed statement with your appeal. Complaints and appeals may be filed over the phone or in writing.

When Can an Appeal Be Filed?

You may file an appeal within sixty (60) calendar days of the date of the notice of the initial organization determination.

Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day time frame.

What Do I Include with My Appeal?
You should include: your name, address, your Member Identification Number, your Medicare number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why our Plan should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

Can I Expedite an Appeal?
You have the right to request and receive expedited decisions affecting your medical treatment in "time-sensitive" situations.

A "time-sensitive" situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize 1) your life or health, or 2) your ability to regain maximum function.

If our Plan or your Primary Care Physician decides, based on medical criteria, that your situation is "time-sensitive" or if any physician calls or writes in support of your request for an expedited review, our Plan or your Primary Care Physician will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request.

Where Can an Appeal Be Filed?
You may file a standard appeal in writing directly to: Signature Advantage, Appeals and Grievances Department, 12201 Bluegrass Parkway Louisville, KY 40299

You may file a standard or expedited appeal by fax to 1-800-880-3263 or by calling Member Services at our toll-free number 1-844-214-8633 TTY users call 711.
Hours of operations: 8:00 a.m. to 8:00 p.m. (7 days a week from October 1 through March 31, except for holidays. Monday to Friday from April 1 through September 30, except for holidays).

What Happens Next?
If you appeal, our Plan will review the decision. If any of the services you requested are still denied after our Plan's review, Medicare will provide you with a new and impartial review of your case by a reviewer outside of our Plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.