

Samaritan Advantage  
Health Plan HMO

# **MEMBER RIGHTS**

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CMS File and Use 10.19.2010

As a member of Samaritan Advantage Health Plan HMO you have the right to make a complaint if you have concerns or problems related to your coverage or care.

There are three different types of complaints that you can make: a grievance, a medication exception, or an appeal.

## GRIEVANCE

A “grievance” is the type of complaint you make if you have any type of problem with Samaritan Advantage Health Plan HMO or one of our plan providers. You would file a grievance if you have a problem with, for example, the quality of your care, waiting times for appointments or time spent in the waiting room, the way your doctors, pharmacists 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 or pharmacy.

If you have a grievance, we encourage you to first call Customer Service at the numbers located on the back of this brochure.

## EXPEDITED GRIEVANCE

If we extend the timeframe to make a coverage decision or appeal, or if we deny your request for an expedited coverage decision or appeal, and you disagree with the decision made by Samaritan Advantage Health Plan HMO, you may request an expedited grievance. By requesting an expedited grievance you are asking us to review your case again for an expedited time frame, and we must resolve and inform you of the decision within 24 hours. You may request an expedited grievance either verbally or in writing by contacting Customer Service at the numbers located on the back of this brochure.

You will be notified verbally within 24 hours from the receipt of your expedited grievance and will receive written notice within 72 hours if it was denied.

We will try to resolve any grievance that you might have over the phone. If you request a written response to your phone grievance, we will respond in writing to you. If we cannot resolve your grievance over the phone, we have a formal procedure to review your grievance. Depending on the nature of the complaint, your grievance is forwarded to an Operations Manager who is responsible for investigating and resolving the matter. 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 grievance. 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 file a grievance to Acentra. Acentra is the quality improvement organization that oversees our plan decisions.

If you are concerned about the quality of care you received, including care during a hospital stay, you can file a grievance directly to Acentra:

Acentra  
2020 SW Fourth Avenue, Suite 520  
Portland, OR 97201  
(503) 279-0100 or toll free: 1-800-344-4354  
Fax: (503) 279-0190

## MEDICATION EXCEPTION

You can ask us to make a medication exception to our coverage rules if you are a member of one of our plans that offer prescription drug coverage: the **Samaritan**

**Advantage Premier Plan HMO, Samaritan Advantage Premier Plan Plus HMO or the Samaritan Advantage Special Needs Plan HMO SNP.** This includes exceptions for:

- Covering your drug even if it is not on our formulary.
- Waiving coverage restrictions or limits on your drug.
- Providing a higher level of coverage for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request. If we approve your medication exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your medication exception request, you can appeal our decision.

## APPEAL

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 Samaritan Advantage Health Plan HMO or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Samaritan Advantage Health Plan HMO 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. If you think that we should have covered a prescription that was denied through the medication exception process, you can file an appeal.

Please see the information that follows for instructions on how to file an appeal.

## **IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS**

For more information about your appeal rights, call us or see your Evidence of Coverage.

### **There are two kinds of appeals you can request:**

**Expedited Requests**—You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting for a standard decision. If your request to expedite is granted, the reviewer must give you a decision no later than 72 hours after receiving your appeal.

**Standard Requests**—You can request a standard appeal for a case that involves coverage or payment for medical or prescription services. The reviewer must give you a decision within specific time frames as described below, depending on whether the request is for medical or prescription services.

## **Time frames for a request regarding your MEDICAL BENEFITS:**

You must file your request for appeal to Samaritan Advantage Health Plan HMO no later than 60 days after receiving the denial for your services. Samaritan Advantage Health Plan HMO will review your appeal request and make a determination as expeditiously as your health requires, but no later than 30 days from the date of the appeal request.

## **Time frames for a request regarding your PRESCRIPTION BENEFITS:**

You must file a request for appeal to Samaritan Advantage Health Plan HMO no later than 60 days from the date of the denial. Samaritan Advantage Health Plan HMO will review your appeal request and make a determination as expeditiously as your health requires, but no later than 7 days from the date of the request.

## **What do I include with my appeal?**

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary), your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

## **How do I request an appeal?**

You or your appointed representative should mail your written appeal request to the address below:

Samaritan Advantage Health Plan HMO  
P.O. Box M  
Corvallis, OR 97339

*If your appeal request is for a prescription drug, please address to “Part D Appeals” and send to the address above.*

## **What happens next?**

After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want. If we turn down part or all of your request for a medical service, we are required to send your request to an independent review organization that has a contract with the federal government and is not part of Samaritan Health Plans. This organization will review your request and make a decision about whether we must give you the care or payment you want. If we turn down part or all of your request for a prescription, you may request an independent review organization to review your appeal.

If you are unhappy with the decision made by the independent review organization, you may ask for an Administrative Law Judge (ALJ) to consider your case and make a decision. The ALJ works for the federal government. In [2010], the dollar value of your contested benefit must be at least [\$130] to be considered by the ALJ.

If you or we are unhappy with the decision made by the ALJ, either of us may be able to ask a Medicare Appeals Council to review your case.

If you or we are unhappy with the decision made by the Medicare Appeals Council, either of us may be able to take your case to a Federal Court. In [2010], the dollar value of your contested medical care must be at least [\$1,260] to go to a Federal Court.



815 NW Ninth Street  
Corvallis, OR 97330  
[www.samhealth.org/SHPlans](http://www.samhealth.org/SHPlans)

**If you need information or help  
regarding a MEDICAL COMPLAINT  
or a PRESCRIPTION COMPLAINT,  
call Samaritan Advantage Health Plan  
Customer Service at:**

(541) 768-4550  
Toll Free: 1-800-832-4580  
TTY: 1-800-735-2900  
8 a.m. to 8 p.m., daily

**Other resources to help you:**

Medicare Rights Center  
Toll Free: 1-888-HMO-9050  
TTY: 1-800-735-2900

Elder Care Locator  
Toll Free: 1-800-677-1116  
1-800-MEDICARE (1-800-633-4227)  
TTY: 1-877-486-2048