Other Important Plan Information

Member Services: (800)499-2793 / TTY/TDD • users should call 711, between
8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to February 14, and
8:00 a.m. – 8:00 p.m., Monday to Friday from February 15 to September 30
12900 Park Plaza Drive, Suite 150 Cerritos CA 90703 caremore.com

Medicare Beneficiaries may contact 1-800-MEDICARE (1-800-633-4227), or visit http://www.medicare.gov for information about Medicare benefits and services including general information regarding the health or Part D benefit.

Typically, you may enroll in a Medicare advantage plan during the annual enrollment period between October 15 and December 7.

Additionally, the following exceptions may allow you to enroll in a Medicare advantage plan outside of these periods. Please read the following statements, if any of the statements apply to you, you may be eligible for a special enrollment period.

- You are new to Medicare.
- You recently moved out of the service area for your current plan.
- You have both Medicare and Medicaid, or the state you live in helps pay for your Medicare premiums.
- You get Extra Help paying for Medicare prescription drug coverage.
- You no longer qualify for Extra Help paying for your Medicare prescription.
- You are moving into, live in, or recently moved out of a long-term care facility (for example a nursing home).
- You recently left a PACE program.
- You recently involuntarily lost your creditable prescription drug coverage (coverage as good as Medicare's).
- You are leaving employer or union coverage.
- You belong to a pharmacy assistance program provided by your state.
- You recently returned to the United States after living permanently outside of the United States.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

Please contact CareMore Health Plan at (800) 499-2793 (TTY/TDD users should call 711) to see if you are eligible to enroll. We are open between 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to February 14, and 8:00 a.m. – 8:00 p.m., Monday to Friday from February 15 to September 30.

CareMore Contract with CMS

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year and the Centers for Medicare and Medicaid Services (CMS) may also refuse to renew the plan's contract, thus resulting in a termination or non-renewal. This may result in termination of the beneficiary's enrollment in the plan. In addition, the plan sponsor may reduce its service area and no longer offer services in the area where the beneficiary resides. Even if a Medicare Advantage Plan leaves the program you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

Low Income Subsidy (LIS)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to one hundred (100) percent of drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about Extra Help, contact your local social security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

Plan Benefits and Cost Sharing

Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change from year to year. The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. Benefits may change on January 1, 2014. All benefits are based on the 2013 calendar year; you must continue to pay your Medicare Part B premium.

Our Grievance, Coverage Determination (including exceptions) and Appeals Process

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

Member Grievances

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:

- Provide our health plan with your name, 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 regarding the _____."
- Provide your name, address and phone number and that of your representative, if applicable.
- You must sign and date the statement.
- Your representative must also sign and date this statement.
- You must include this signed statement with your grievance.

What Is a Grievance?

A grievance is a type of complaint that does not involve payment, denial or discontinuation of services by CareMore Health Plan or a Contracting 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 your plan; waiting times on the phone, at a network pharmacy, in the waiting room, or in the 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 doctor's office.

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 timeframe.

Expedited Grievance

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

Where Can a Grievance Be Filed?

A grievance may be filed in writing directly to us or contacting our Member Services Department at our toll free number 1-800-499-2793 (TTY/TDD 711), between 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to February 14, and 8:00 a.m. – 8:00 p.m., Monday to Friday from February 15 to September 30. You may also contact our Member Services Department and request the facsimile number for Appeals and Grievances.

Why File a Grievance?

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

Coverage Determinations

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 the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our 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.

When Can a Coverage Determination/ Exception Be Requested?

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

1. Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary).
   a. 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.
   b. You may ask for an exception if your network pharmacy can't fill a prescription as written.
2. Removing a restriction on the plan's coverage for a covered drug.
   a. You may ask for an exception if you or your prescriber believe that a coverage rule (such as a prior authorization) should be waived.

3. Changing coverage of a drug to a lower cost-sharing tier. (Tier Exception)
   a. 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.
4. Request for payment.
   a. You may ask us to pay for a prescription that you already paid for

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 legally allowed to write prescriptions) can request a coverage determination for you on your behalf.

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 this medical information from your doctor or other prescriber when you ask for the exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our 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 for a review of our 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, your representative, or your prescriber can request an exception or expedited exception by writing directly to us or contacting our Member Services Department at our toll free number 1-800-499-2793 (TTY/TDD 711), between 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to February 14, and 8:00 a.m. – 8:00 p.m., Monday to Friday from February 15 to September 30. You may also contact our Member Services Department and request the facsimile number for Appeals and Grievances.

Our plan has 72 hours (for a standard request) or 24 hours (for an expedited request) from the date it gets your request to notify you of its decision.

Member Appeals

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:

- Provide our health plan with your name, 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 CareMore Health Plan and/or CMS regarding the denial or discontinuation of medical services."
- Provide your name, address and phone number and that of your representative, if applicable.
- You must sign and date the statement.
- Your representative must also sign and date this statement.
- You must include this signed statement with your appeal. Complaints and appeals may be filed over the phone or in writing.

What Is an Appeal?

An appeal is a type of complaint you make when you want us to review a decision that was made regarding coverage of a service, the amount we paid for a service, 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:

- CareMore Health Plan refuses to cover or pay for services you think CareMore Health plan should cover.
- CareMore Health Plan or one of the Contracting Medical Providers refuses to give you a service you think should be covered.
- CareMore Health Plan or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving.
- If you think that CareMore Health Plan is stopping your coverage too soon.

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 timeframe.

Where Can an Appeal Be Filed?

An appeal may be filed in writing directly to us or contacting our Member Services Department at our toll free number 1-800-499-2793 (TTY/TDD 711), between 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to February 14, and 8:00 a.m. – 8:00 p.m., Monday to Friday from February 15 to September 30. You may also contact our Member Services Department and request the facsimile number for Appeals and Grievances.

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 CareMore Health Plan paid for a service.

What Do I Include With My Appeal?

You should include: your name, address, member ID 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 your 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.

What Happens Next?

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

Fast Decisions/Expedited Appeals

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 timeframe of the standard decision-making process could seriously jeopardize:

- Your life or health, or
- Your ability to regain maximum function.

If CareMore Health 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, CareMore Health 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.