Anthem Medicare Advantage Appeals Language

Please note: the Retiree First advocates can handle appeals or any type of dispute directly with the carrier and advise the member what if any additional steps may be required. Upon resolution of any of these type of matters, the Retiree First member advocates will make proactive outreach to ensure that members feels the situation was handled properly and to their satisfaction.

Appeals Language (see following page for additional appeal information):

1. How to contact us when you are making a complaint about your medical care
   Step 1: Contact us promptly – either by phone or in writing.
   Step 2: We look into your complaint and give you our answer.
   • 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 within 30 calendar days. If we need more information and the delay is in your best interest or if you ask 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 we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

2. You can make a complaint about us or one of our in-network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

Method	Complaints – Contact Information
CALL	1-833-848-8730 Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Anthem BC Health Insurance Company Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
MEDICARE WEBSITE	You can submit a complaint about your plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

3. If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal.
   Call Member Services
   Get free help from your State Health Insurance Assistance Program
   Your doctor can make a request for you
   You can ask someone to act on your behalf
   You have the right to hire a lawyer

   Level 1 Appeal – call or write to Anthem to appeal the coverage decision
   Level 2 Appeal - conducted by an Independent Review Entity . This organization decides whether the decision we made should be changed.
   Level 3 Appeal - a judge (called an Administrative Law Judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.
   Level 4 Appeal - the Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.
   Level 5 Appeal A judge at the Federal District Court will review your appeal.

Please scroll to end to read all information.

MEDICARE FIVE LEVELS OF APPEALS

LEVEL 1 Redetermination

Part A & Part B
Fee for Service
- 120 days to file
- MARC Redetermination 60 day time limit

Part C – MA
60 days to file
Standard Process
- Health plan Reconsideration
- Fee for Service 30 days time limit
- Payment: 60 day time limit

Expedited Process
- Health Plan Reconsideration: 72 hour time limit

Part D – Drug
60 days to file
Standard Process
- MA-PD/PDP Redetermination and payment: 7 day limit

Expedited Process
- MA PD/PDP
- Redetermination benefits: 72 hour time limit

LEVEL 2 Reconsideration

Part A & Part B
- 180 days to file
- Qualified Independent
- Contractor
- (QIC) Reconsideration: 60 day time limit

Part C - MA
Automatic IRE reviewed if plan uphold dental
Standard Process
- IRE Reconsideration Preservice: 30 day time limit
- Payment: 60 day time limit

Expedited Process
- IRE Reconsideration Preservice: 72 hour time limit

Part D – Drug
60 days to file
Standard Process
- IRE Reconsideration Preservice: 7 days time limit

Expedited Process
- Benefits IRE Reconsideration: 72 hour time limit

LEVEL 3 Administrative

Part A & Part B
- 60 days to file
- Office of Medicare hearings & Appeals AIC =>160
- 90 day time limit

Part C – MA
- 60 days to file
- Office of Medicare Hearings & Appeals
- AIC =>160
- No Statutory time limit for processing

Part D – Drug
60 days to file
Standard Process
- IRE Reconsideration Preservice: 90 day limit

Expedited Process
- Office of Medicare hearings & Appeals AIC =>160 10 day limit

LEVEL 4 – Council Review

Part A & Part B
- 60 days to file
- Medical Appeals Council 90 day time limit

Part C - MA
- 60 days to file
- Medical Appeals Council
- No statutory time limit for processing

Part D – Drug
60 days to file
Standard Process
- Medicare Appeals Council
- 90 day time limit

Expedited Process
- Medicare Appeals Council Expedited Decision
- 10 day time limit

LEVEL 5 – Judicial Review

Part A & Part B
- Federal District Court AIC => $1600

Part C - MA
- 60 days to file
- Federal District Court
- AIC => $1600

Part D – Drug
- 60 days to file
- Federal District court AIC => $1600