



APPEAL & GRIEVANCE PROCESS

Freedom Health has a coverage determination, appeals, and grievance process for plan members that follows CMS guidelines and uses CMS forms. If you think that Freedom Health should cover a certain benefit, or a certain medication, or request an exception to formulary tiering you have the right to request a coverage determination.

MEDICARE ADVANTAGE APPEALS AND GRIEVANCES

Filing a Grievance

We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Freedom Health, Inc. Grievance Procedure. You should use the Freedom Health, Inc. Grievance Procedure discussed below for complaints that do not involve coverage decisions such as those described above. If you have questions about what type of complaint process to use, please call Members Services at 1-800-401-2740 or TTY at 1-800-955-8771 7 days a week from 8:00 a.m. to 8:00 p.m. beginning November 15, 2006 through March 1, 2007 and Monday through Friday from March 2, 2007 through November 14, 2007. You can also write to the Grievance and Appeals Department directly. If you call Member Services, they can send you a Grievance Form to fill out, or they can help you by getting the information on the phone. You can also write to us about your complaint without a Grievance form. Let us know about your complaint, including how to contact you if we have questions.

When we get your letter, we will let you know within three days that we have started the Grievance Procedure. 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 complaint. You can start a grievance that you want resolved faster than the “standard” grievance. You can file a “fast” or expedited grievance if Freedom Health does not allow a “fast” initial decision” or a “fast” appeal” or reconsideration when you think we should. You can also ask for a “fast” grievance if we have decided to extend the time to decide an initial decision or respond to your appeal. When you request a “fast”

grievance”, we will let you know by phone within twenty-four hours (24) if we can do a “fast” grievance, or if it will be done as a “standard” grievance. Please read your Evidence of Coverage (EOC) for more details.

Filing an Appeal

You can file an appeal against an “initial decision” made by Freedom Health, Inc. For example, if you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an “initial decision” about whether the treatment you want is covered by the Freedom Medicare Plan. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Freedom Health, Inc., or may ask us whether we will authorize the treatment. Also, if you ask us to pay for medical care you have already received, this is a request for an “initial decision” about payment for your care. If our initial decision is to deny your request (this is sometimes called an “adverse initial decision”), you can “appeal” the decision. When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of the Freedom Medicare Plan apply to your specific situation.

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your authorized representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at:

Freedom Health, Inc.,
Attention: Appeals & Grievance Department.
P.O. Box 1162,
Pinellas Park, Florida 33780,

You can call Member Services at 1-800-401-2740 or TTY at 1-800-955-8771 to learn how to name your authorized representative or to request an initial determination. The Member Services hours of operation are 7 days a week from 8:00 a.m. to 8:00 p.m. beginning November 15, 2006 through March 1, 2007 and Monday through Friday from 8:00 a.m.



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to 8:00 p.m. from March 2, 2007 through November 14, 2007.

A decision about whether we will cover medical care can be a “standard” decision that is made within the “standard” time frame (typically within 14 days), or it can be a “fast” decision that is made more quickly (typically within 72 hours). A “fast” decision is sometimes called an “expedited organization determination.” You can ask for a “fast” decision only if you or any doctor believe that waiting for a “standard” decision could seriously harm your health or your ability to function. You cannot get a “fast” decision on requests for payment for care you have already received.

To ask for a “standard” decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Freedom Health, Inc., P.O. Box 1162, Pinellas Park, Florida 33780, Attention: Appeals & Grievance Department. You, any doctor, or your authorized representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 1-800-401-2740 (for TTY, call 1-800-955-8771). Or, you can deliver a written request to Freedom Health, Inc., P.O. Box 1162, Pinellas Park, Florida 33780, Attention: Grievance and Appeals Department or fax it to 727-471-2108. For requests made outside of regular weekday business hours, please call 1-800-401-2740. Be sure to ask for a “fast” or “72-hour” (expedited organization determination) review. Please read your Evidence of Coverage (EOC) for more details.

If you ask for a “fast” initial decision without support from a doctor, we will decide if your health requires a “fast” decision. If we decide that your medical condition does not meet the requirements for a “fast” initial decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” review, we will automatically give you a “fast” decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a “fast” review. It will also tell you about your right to ask for a “fast” grievance.” If we deny your request for a “fast” initial decision, we will instead give you a “standard” decision (typically within 14 calendar days; see below). If any doctor asks for a “fast” decision for you, or supports you in

asking for one, and the doctor indicates that waiting for a “standard” decision could seriously harm your health or your ability to function, we will automatically give you a “fast” decision.

For standard initial decisions, we will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. For “fast” expedited organization determinations, we will tell you our decision by phone as soon as we make the decision. If we deny your request (completely or in part), then within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

If Freedom Health denies any part or the entire initial request, you may ask for a reconsideration of our decision. This is an “appeal” or “request for reconsideration”. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

You can make a standard or fast appeal and the procedures for deciding on a standard or a fast appeal are the same as those described for a standard or fast initial decision detailed above. However, providers who do not have a contract with Freedom Health, Inc. must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal. You need to file your appeal within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline. We must gather all the



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information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information. You can give us your additional information in any of the following ways:

In writing to:

Freedom Health, Inc.,
Attn: Grievance and Appeals Department.
P.O. Box 1162
Pinellas Park, Florida 33780.

By fax, at:

727-471-2108

By phone at:

1-800-401-2740 or TTY at 1-800-955-8771.
Hours of operation beginning November 15, 2006 through March 1, 2007 are 7 days a week and from March 2, 2007 through November 14, 2007 Monday through Friday from 8:00 a.m. to 8:00 p.m.

In person, at:

Freedom Health, Inc.,
5501 49th Street North
St. Petersburg, Florida 33709.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-401-2740 (or TTY at 1-800-955-8771), Freedom Health, Inc., Attention: Grievance and Appeals Department, P.O. Box 1162, Pinellas Park, Florida 33780. We are allowed to charge a fee for copying and sending this information to you. Please read your Evidence of Coverage (EOC) for more details.

After we receive your standard appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30

calendar days (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

After we receive your fast appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to the Independent Review Entity.

For a payment appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal automatically goes to the IRE

If we decide in your favor on a standard request at organization determination or reconsideration stage, we must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received your request decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision. If we approve an expedited organization determination or re-consideration, we must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

For payment determinations, we have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. If we decide in your favor, then we must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.



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If we decide completely in your favor the following will occur:

If we deny any part of your appeal, then your appeal automatically goes on to the Independent Review Entity for review of your case. This independent review organization contracts with the federal government and is not part of Freedom Health, Inc. We will tell you in writing that your appeal has been sent to this organization for review. For a standard appeal, we must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal. For a fast appeal, we must send all of the information about your appeal to the independent review organization within 24 hours of our decision. For payment appeals, we must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

You are entitled to further appeals even if the IRE rejects your appeal. For details of the further appeal process please read the relevant sections in your Evidence of Coverage (EOC).

PART D GRIEVANCES, COVERAGE DETERMINATIONS, AND APPEALS

What is a Part D grievance?

A grievance is any complaint other than one that involves a benefit coverage or payment for Part D prescription drug benefits determination. You would file a grievance if you have any type of problem with the Freedom Medicare Plan or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

Filing a Grievance

Our Member Services Department can send you a Grievance Form (or you can download one from the link below) to fill out, or you can make an oral grievance. You can also write to the Part D

Grievance and Appeals Department directly, with or without a Grievance Form at: Freedom Health, 5501 49th Street North, St. Petersburg, Florida 33709, Attention: Part D Grievance and Appeals Department, or fax the Grievance Form to 1-727-471-2108. For requests made outside regular business hours, please call 1-800-401-2740. Member Services hours of operation beginning November 15, 2006 through March 1, 2007 will be 7 days a week from 8:00 a.m. to 8:00 p.m. From March 2, 2007 through November 14, 2007, hours of operation will be Monday through Friday from 8:00 a.m. to 8:00 p.m.

When you call or write us, we will let you know within three days that we have started the Grievance Procedure. 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 complaint. We may extend the timeframe 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.

In certain cases, you have the right to ask for a “fast” grievance, meaning your grievance will be decided within 24 hours. You can file a “fast” grievance if Freedom Health does not allow a “fast” coverage determination or a “fast” appeal or reconsideration when you think we should. You can also ask for a “fast” grievance if we have decided to extend the time to decide an initial decision or respond to your appeal. When you request a “fast” grievance, we will let you know by phone within twenty-four (24) hours if we can do a fast grievance, or if it will be done as a standard grievance. If we do a “fast” grievance, we will let you know the result in three days. We will call you and mail you the results of the grievance.

Part D Coverage Determination

If your doctor or pharmacist tells you that a certain prescription drug is not covered under the Plan you ask us for a coverage determination. Coverage determinations include exceptions requests. You have the right to ask for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request. With the coverage determination



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decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

Note 1: You must contact us if you would like to request a coverage determination (including an exception). You can request an appeal only if we have not issued a coverage determination.

Note 2: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment we require you to pay for the drug.

Note 3: When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of the Freedom Medicare Plan apply to your specific situation.

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your appointed representative. An Appointment of Representative form (CMS-1696) can be found on the link noted at the end of this section. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Freedom Health, Inc., P.O. Box 1162, Pinellas Park, Florida 33780, Attention: Grievance and Appeals Department. You can call us at 1-800-401-2740 or TTY at 1-800-955-8771 to learn how to name your appointed representative.

Standard or Fast Coverage Determinations

A “standard” coverage determination is typically made within 72 hours of a request. If you or your doctor believes that waiting for a standard decision could seriously harm your health or your ability to function, you can ask for a “fast” decision. A “fast” coverage determination is made more quickly, typically within 24 hours. You cannot get a fast

decision if you are requesting payment for a Part D drug that you already received.

To ask for a “standard” or “fast” decision, you, your doctor, or your appointed representative should call the Member Services Department at 1-800-401-2740 (for TTY, call 1-800-955-8771). The hours of operation for the Member Services Department are 7 days a week from 8:00 a.m. to 8:00 p.m. beginning November 15, 2006 through March 1, 2007. From March 2, 2007 through November 14, 2007 hours of operation will be Monday through Friday from 8:00 a.m. to 8:00 p.m.

Or, deliver a written request to:
Freedom Health, Inc.,
Attn: Grievance and Appeals Department
5501 49th Street North,
St. Petersburg, Florida 33709

Or fax it to 727-471-2108

If your request is for a “fast” review, be sure to mention or ask for a “fast,” “expedited,” or “24-hour” review.

If your doctor asks for a “fast” coverage determination for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a “fast” coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard timeframe.

If your request involves a request for an exception (including a formulary exception, tier exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy



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requirements), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary. If you are requesting an exception, you should submit your prescribing physician's supporting statement with the request, if possible. A Provider Drug Evaluation form is also available below.

If we do not approve your coverage or exception request (standard or fast), we must explain why, and tell you of your right to appeal our decision. If you have not received an answer from us within time (72 hours for standard and 24 hours for fast) after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case. If we do not grant you or your physician's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

For a coverage determination or exception decision about a Part D drug, which includes a request about payment for a Part D drug that you already received that is in your favor, we must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours for standard and 24 hours for fast, after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours for standard and 24 hours for fast, after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide completely or only partly against you. For example, if we deny your request for payment for a Part D drug that you have already

received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you all that you requested, you have the right to appeal the decision.

Forms

We use template CMS forms. You can access the forms from the Tools and Resources Section on our Website or from the CMS website link provide below.

Member Grievance Form
Member Coverage Determination Form
Instructions - Coverage Determination Request
Medicare Part D Coverage Determination Form
Request For Prescription Info or Change
Appointment of Representative Form

CMS WEBSITE:

http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp

Filing an Appeal (Re-determination or Re-consideration)

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination or exception request. You can appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception you can appeal. A coverage determination, may be appealed if you disagree with our decision.

The first level of appeal is called a re-determination. There are also four other levels of appeal that an enrollee may request. For details on the other appeal levels, please refer to your Evidence of Coverage (EOC).

Level 1 Appeals

You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a



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fresh look. How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" coverage determination. We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information. You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline. Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

You or your appointed representative may file the standard appeal. A "fast" appeal may be filed by you, your appointed representative, or your prescribing physician. Freedom Health use template CMS forms. A Member Re-determination Form, Member IRE Reconsideration Form and a Provider Appeal Form and instructions are provided on our website under the Tools and Resources section. Please call Member Services at 1-800-401-2740 or TTY at 1-800-955-8771 if you need help with filing an appeal or for filing an appeal (or you can use the form provided below). The Member Services hours of operation beginning November 15, 2006 through March 1, 2007 are 7 days a week from 8:00 a.m. to 8:00 p.m. From March 2, 2007 through November 14, 2007, hours of operation will be Monday through Friday from 8:00 a.m. to 8:00 p.m. For requests made outside regular weekday business hours, please call 1-800-401-2740. Be sure to ask for a "fast," "expedited," or "72-hour" review if you need one.

You can give us your additional information in any of the following ways:

In writing to:

Freedom Health, Inc.,
Attn: Grievance and Appeals Department.
P.O. Box 1162
Pinellas Park, Florida 33780.

By fax, at:

727-471-2108

By phone at:

1-800-401-2740 or TTY at 1-800-955-8771.
Hours of operation beginning November 15, 2006 through March 1, 2007 are 7 days a week and from March 2, 2007 through November 14, 2007 Monday through Friday from 8:00 a.m. to 8:00 p.m.

In person, at:

Freedom Health, Inc.,
5501 49th Street North
St. Petersburg, Florida 33709.

For a standard appeal about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. For a fast decision about a Part D drug that you have not received, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to do so.

If the appeal is decided completely in your favor, we must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal (within 72 hours or sooner, if your health would be affected by waiting). We must send payment to you no later than 30 calendar days after we receive your upheld appeal to reconsider our coverage determination.

If the decision of the appeal (re-determination) is to continue the denial of coverage or payment or if we do not give you our decision within the time frames, Freedom Health will automatically forward your case for reconsideration to an independent review entity



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(IRE) contracted by Medicare to review Managed Care Organizational denials.. This IRE has no affiliation with the health plan. Once the review has been filed, the IRE has 30 calendar days (for a standard request for coverage), 60 calendar days (for a request to pay you back) or 72 hours (for expedited requests for coverage) to notify you of their decision.. Once they have made a determination on whether to agree or disagree with us, they will notify you of the decision and will provide further appeal instructions. For detailed information on this appeal and the remaining appeals available to you, please review your Evidence of Coverage (EOC).