INTERNAL GRIEVANCE PROCESS

I. GRIEVANCES: The Consolidated Associations of Railroad Employees (**CARE**) maintains an internal grievance process through which members may seek resolution of grievances other than claims denials or adverse organization determinations. Grievances involving other than claims denials or adverse organization determinations may be resolved only through **CARE**'s internal grievance process. Examples of such grievances include:

- complaints about waiting times, physician demeanor and behavior, or adequacy of health care facilities
- involuntary disenrollment issues
- Quality of Care issues may be resolved through **CARE**'s internal grievance process or by filing a complaint with the QIO* or both.

*Quality Improvement Organization (QIO) is a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare. A QIO is paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think coverage for their hospital stay is ending too soon. You can find the QIO in your state by calling the national (1.800.633.4227) telephone number.

If you have a complaint, we encourage you to first call our **CARE** Customer Service at 1.800.334.1330. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints listed below under **"Procedures**."

II. PROCEDURES (Filing of Grievances*):* If you have a complaint involving other than a claims denial or an adverse organization determination, you may file an oral or a written grievance with the Administrator of **CARE** within 60 days of the event underlying the complaint. The written grievance must include your name, address and a full explanation of your complaint, including specific dates, persons, places and events relevant to your complaint. Please include supporting documentation, if any, when filing your written grievance. To submit an oral grievance, call **CARE** Customer Service at 1.800.334.1330. Mail or deliver your written request to the following address:

INTERNAL GRIEVANCE PROCESS
CARE
4912 Midway Drive
Post Office Box 6130
Temple, Texas 76503-6130

Internal Committee Review
After your oral or written grievance is received, the Administrator will review your grievance for completeness. If the Administrator does not think the grievance is complete, additional information may be requested from you. Once the Administrator deems your grievance complete, your grievance will be

referred to an Internal Committee of three (3) to five (5) **CARE** Administrative staff members appointed by the Administrator. The Internal Committee will include among its members at least one **CARE** administrative staff member from the department relevant to your complaint. For example, if your grievance involves an involuntary disenrollment issue, at least one of the Internal Committee members shall be from **CARE**'s Member Services Department. If your grievance involves a complaint about physician demeanor or behavior, at least one of the Internal Committee members shall be from **CARE**'s Credentialing Department.

The Internal Committee will review your complaint and make a decision within 30 days of the receipt of your oral or written grievance unless special circumstances (such as the need for additional information from you and/or other involved parties) require a 14 day extension. If such an extension is necessary, you will be notified and will receive a decision from **CARE** no later than the 14 day extension. If the grievance was oral, the notification of the decision will be oral unless you request the decision in writing. If the grievance was in writing, or you request the oral decision in writing, the decision will set forth in writing the findings and resolution of the complaint. All grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing and the response must include a description of the member's right to file a written complaint with the QIO.

You have the right to file an expedited grievance if a request for an expedited determination or appeal for service was denied and the regular time frame was applied or we needed extra days (14) to consider your request or appeal for service. An expedited grievance must be decided within 24 hours if our decision to deny or delay puts your life or health at risk. If we determine that we should have expedited your request, we will do so and notify you of our decision.

MEDICARE CLAIM & APPEAL PROCEDURES

Introduction: The terms we, us, and **CARE** are used throughout this Section, but the appeal or decision may not be the type that **CARE** would make as an HCPP. Carefully examine your case, the benefits and the type of request. It will delay your process if you send a decision request to **CARE** that should go to Railroad Medicare, Original Medicare, or a Medicare Intermediary on facility services.

This section gives the rules for making complaints about Medicare services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a **CARE** member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from **CARE** Medicare Plans or penalized in any way if you make a complaint.

Please refer to Original Medicare rules in your current year's Medicare & You book for additional guidance on your appeal rights under Original Medicare. If you do not have a current Medicare & You book, please call Medicare at 1.800.633.4227 to get a copy.

To file a CARE Medicare Secondary Plan payment appeal: You have the right to appeal payment amounts or denied payments by your **CARE** Medicare Secondary Plan. The steps that are available to you are as follows:

• You, your representative or a participating provider must file your appeal in writing within 60 days of the time the claim for Medicare secondary payment was processed by **CARE**. Additional information that may aid in reconsidering the payment must be submitted at the time of your appeal. **CARE** must return a written determination to you within 30 days from the date of receipt of your written appeal.

• Should we uphold our initial payment decision and you do not agree you can next appeal to the **CARE** Board of Directors within 60 days of that decision. The **CARE** Board of Directors has 30 days in which to make a decision on this appeal. Mail your **CARE** payment appeal to: **CARE**, Attn: Corporate Secretary; P.O. Box 6130; Temple, Texas 76503-6130

How to make complaints in different situations: Who to contact for complaints about your Medicare services or payments depends on who processed the claim for your Original Medicare benefits. As a member of the **CARE** Medicare Plans, you continue to access your benefits through Original Medicare whether or not the provider is participating with **CARE**. Being a member of the **CARE** Medicare Plans includes continued benefit coverage from Original Medicare.

• **CARE** HCPP can only perform your Medicare appeal if we processed the original Part B claim from a **CARE** participating HCPP provider.

• All of your appeals for Medicare Part B claims that were originally processed by Railroad Medicare (Palmetto GBA) must go directly to them and not **CARE**. For more information on how to file an Original Medicare appeal, please refer to your current Medicare & You book.

• All of your appeals for Medicare Part A benefits are made to the Original Medicare intermediary that processed your claim. **CARE** does not process your Medicare Part A services. However, **CARE** does pay secondary to Medicare for your Part A benefits unless listed as an exclusion on page 14 of your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide.

CARE HCPP participating physicians can send your claims to either **CARE** or Railroad Medicare (Palmetto GBA) because you are still using your Original Medicare benefits. If a **CARE** participating physician sends your claims to Railroad Medicare, we cannot perform a Medicare appeal for you. Your appeal must go to Railroad Medicare.

Railroad Medicare must pay all of your Medicare Part B claims for services from other than HCPP providers that do not participate with **CARE**. As a **CARE** Medicare member, you may choose to get care from nonparticipating HCPP providers anywhere *(except for Topeka Medicare members, refer to page 4 of your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide*), and at any time using your Original Medicare benefits.

When **CARE** HCPP participating physicians send your claims to Railroad Medicare (Palmetto GBA), we cannot automatically pay your **CARE** Medicare Secondary Plan benefits; either you or the physician must send the Medicare Summary Notice (MSN) and a copy of the claim to **CARE** to receive your payment. This section tells you how to complain about services or payment in each of the following situations:

- Part 1. Complaints about what benefit or service we will provide you or what we will pay for/cover.
- Part 2. Complaints if you think you are being discharged from the hospital too soon.
- Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For more information about grievances, including how to file a grievance, see page 14 of your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide.

Complaints about what benefit or service CARE HCPP, Railroad Medicare, or Original Medicare will provide you or what they will pay for.

What Are Complaints About Your Services Or Payment For Your Care?: If you are not getting the care you want, and you believe that Medicare covers this care.

- If you are told that Medicare does not cover the medical treatment your doctor or other medical provider wants to give, and you believe that Medicare covers this treatment.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe Medicare should cover, but we have refused to pay for this care because we say it is not covered.

What Is An Organization Determination?: An organization determination is the initial decision about whether Medicare will provide the medical care or service you request, or pay for a service you have already received. If the initial decision is to deny your request, you can appeal the decision by going on to Appeal Level 1 (see below). You may also appeal if Medicare or **CARE** has failed to make a timely initial decision on your request. When an initial decision is made, it is the interpretation of how the benefits and services that are covered by Original Medicare apply to your specific situation.

Your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide and your current Medicare & You book, and any amendments you may receive, describe the benefits and services covered by Medicare and **CARE**, including any limitations that may apply to these services. This booklet also lists exclusions (services that are not covered by Original Medicare and/or **CARE**).

Who May Ask For An Initial Decision About Your Medical Care or Payment? Depending on the situation, you can ask 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 **CARE**, P.O. Box 6130, Temple, Texas 76503-6130. You can call us at 1.800.334.1330, TTY use the national number 711, to learn how to name your authorized representative. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Do You Have A Request For Medical Care That Needs To Be Decided More Quickly Than A Standard Time Frame? A decision about whether Medicare covers medical care can be a standard decision that is made within the standard time frame (typically within 14 days; see below), or it can be a fast decision that is made more quickly (typically within 72 hours; see below). 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.

Asking For a Standard Decision: To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail request in writing to the following address: **CARE**, P. O. Box 6130, Temple, Texas 76503-6130. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

Asking For a Fast Decision: You, any doctor, or your authorized representative can ask for a fast decision (rather than a standard decision) about medical care by calling us at 1.800.334.1330 (for TTY, call the national number 711). Or, you can deliver a written request to **CARE** at 4912 Midway Drive, Temple, Texas 76502. You can send a written request to **CARE**, PO Box 6130, Temple, Texas 76503-6130, or fax it to 254.774.7652. Be sure to ask for a fast or 72-hour review. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

• 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 give you a fast decision.

• If you ask for a fast 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 decision, 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 give you a standard decision.

What Happens Next When You Request An Initial Decision? If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

1. For a decision about payment for care you already received.

- We have 30 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, 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 days of your request, you can appeal (also called reconsideration) this decision.

2. For a standard initial decision about medical care.

- We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). If we take additional days, we will notify you in writing. If you feel that we should not take additional days, you can make a specific type of complaint called a *grievance*. Page 14 of your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide tells how to file a grievance. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

- 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. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

- If you have not received an answer from us within 14 days of your request, or by the end of an extended time period, you have the right to appeal.

3. For a fast decision about medical care.

- If you receive a fast decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it — sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you file a fast *grievance*. Page 14 of your 2015 Health Care Prepayment Plan & Medicare Secondary Plan Benefit Guide tells how to file a grievance.

- We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

Appeal Level 1: If **CARE** HCPP or the Original Medicare claims processor denies your request for coverage or payment of a service, you may ask us (or them) to reconsider the decision. This is called an appeal or request for reconsideration. Please call us at 1.800.334.1330 if you need help in filing your appeal. We give your request to different people than those who were involved in making the initial decision. This helps ensure that we give your request a fresh look. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

If your appeal concerns a decision we, or Original Medicare made about authorizing medical care, 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 *initial decision*.

Getting Information To Support Your Appeal. 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 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. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

If the decision is one that would be made by **CARE**, you can give us your additional information in any of the following ways:

- In writing, to **CARE**, P. O. Box 6130, Temple, Texas 76503-6130.
- By fax, at 254.774.7652.
- By telephone — if it is a fast appeal — at 1.800.334.1330.
- In person, at **CARE**, 4912 Midway Drive, Temple, Texas 76502

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at the above address. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How Do You File Your Appeal Of The Initial Decision? The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the rules under "Who may ask for an *initial decision* about medical care or payment?" If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How Soon Must You File Your Appeal? You need to file your appeal within 60 days after you are notified of the initial decision. You will be given more time if you have a good reason for missing the deadline. To file your appeal you can call us at 1.800.334.1330 or send the appeal to us in writing at the above address. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

You may also send your appeal to the Railroad Retirement office. Please note that sending your appeal to that office instead of to us will cause a delay when we begin the appeal, since that office must forward your appeal request to us.

What if you want a "fast" appeal? The rules about asking for a fast appeal are the same as the rules about asking for a fast decision. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How soon must we decide on your appeal? How quickly the decision is made on your appeal depends on the type of appeal. Remember, **CARE** can only perform an appeal on a Medicare claim that was processed by us. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

1. For a decision about payment for care you already received.
   - After your appeal is received, a decision must be made within 60 days. If the decision is not made within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.

- Remember, this must be medical care you want to receive from a **CARE** participating physician. After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227. 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 days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

- Remember, this must be medical care you want to receive from **CARE** participating physician. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227. After we receive your 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 there is some information is missing which can help you, we can take up to 14 more 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 Appeal Level 2

What Happens Next If We Decide Completely In Your Favor?

1. For a decision about payment for care you already received.

- We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

2. For a standard decision about medical care.

- We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care no later than upon the expiration of the date of the extension. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

3. For a fast decision about medical care.

- We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your care no later than upon the expiration date of the extension. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

What Happens Next If We Deny Your Appeal? If we deny any part of your appeal in Step 2, then your appeal automatically goes on to Appeal Level 2 where an independent organization will review your case. This independent review organization contracts with the Federal government and is not part of **CARE** or Original Medicare. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. For a decision about payment for care you already received.

- We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your Level 1 appeal.

2. For a standard decision about medical care.

- 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 days after we received your Level 1 appeal.

3. For a fast decision about medical care.

- We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If **CARE** HCPP, or the Original Medicare claims processor denies any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization.

What Independent Review Organization Does This Review? In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with Centers for Medicare and Medicaid Services (CMS), the government agency that runs the Medicare program. This organization has no connection to us. We, or the involved Original Medicare claims processor will tell you when your appeal is sent to this organization. You have the right to get a copy of your case file that is sent to this organization.

How Soon Must The Independent Review Organization Decide? After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For an appeal about payment for care, the independent review organization has up to 60 days to make a decision.

2. For a standard appeal about medical care, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the Independent Review Organization Decides Completely In Your Favor. The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For an appeal about payment for care, **CARE** or the responsible Original Medicare claims processor must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care, **CARE** or Original Medicare must authorize the care you have asked for within 72 hours after receiving notice of the decision, or provide the care no later than 14 days after receiving the decision.

3. For a fast appeal about medical care, **CARE**, or Original Medicare must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case at appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical claim does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

How Soon Does the Judge Make A Decision? The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If The Judge Decides In Your Favor: **CARE** or Original Medicare must pay for, authorize, or provide the service you have asked for within 60 days from the date the decision notice is received. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If The Judge Rules Against You: You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review**.**

Appeal Level 4: Your case may be reviewed by a Medicare Appeals Council.

This Council Will First Decide Whether To Review Your Case: The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you, **CARE** or Original Medicare may request a review by a Federal Court Judge. The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How Soon Will The Council Make A Decision? If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If The Council Decides In Your Favor: **CARE** or Original Medicare must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If The Council Decides Against You: If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you, **CARE** or Original Medicare have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court: In order to request judicial review of your case, you must file a civil action in a United States District Court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you, **CARE** or Original Medicare may ask a Federal Court Judge to review the case.

How Soon Will The Judge Make A Decision? The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.