

How to File a Grievance, an Organization/Coverage Determination or an Appeal for DualCare Plus (HMO D-SNP)

This is a summary of our grievance, coverage determination (including exceptions) and appeals processes.

Below we summarize how to ask for coverage decisions, make appeals or make a complaint if you are having trouble getting the medical care you think is covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage, and asking us to continue covering hospital care and certain types of medical services if you think your coverage is ending too soon.

For step-by-step guidance please refer to the Evidence of Coverage (EOC) for your plan in Chapter 9, *“What to do if you have a problem or complaint (coverage decisions, appeals, complaints)”*.

For plan contact information refer to the Evidence of Coverage (EOC) for your plan in Chapter 2, *“Important phone numbers and resources”*.

How to make a Complaint or Grievance about medical coverage or Part D prescription drugs

The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, customer service or other concerns that are not about benefits or coverage. Please refer to your Evidence of Coverage (EOC) Chapter 9, Section 11, *“How to make a complaint about quality of care, waiting times, customer service, or other concerns”* for step-by-step instructions.

Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. 1-800-346-4643, TTY: 711, 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days.

We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under *"How to contact us when you are making a complaint about your medical care"* or for Part D prescription drug complaints *"How to contact us when you are making a complaint about your Part D prescription drugs."*

If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.

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.

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.

If you have a concerns about the quality of care you received

You can make a quality of care complaint to us by using the process outlined above. When your complaint is about quality of care, you also have two extra options:

- You can make your complaint about the quality of care you received directly to the Quality Improvement Organization (QIO) (without making the complaint to us). The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
- You can make your complaint to both our plan and the QIO at the same time.

You can also tell Medicare about your complaint

To submit a complaint to Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also visit <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

How to ask for a Coverage Decision for medical coverage

A coverage decision is any decision we make about your benefits and coverage, or about the amount we will pay for your medical services or Part B drugs.

If you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. You can call, write, or fax a request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this. When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines.

A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request. However, for a request for a medical item or service we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell

you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If your health requires it, ask us to give you a "fast decision." A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours. There are requirements that must be met to qualify for a "fast decision." For example, you can get a fast decision only if you are asking for coverage for medical care you have not yet received or only if using the standard deadlines could cause serious harm to your health or hurt your ability to function. However, for a request for a medical item or service we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

How to Ask for a Coverage Decision for Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. For Part D prescription drugs, you can ask us to make exceptions including asking us to cover a Part D drug that is not on the plan's List of Covered Drugs (Formulary), ask whether a drug is covered for you and whether you meet the requirements for coverage. You may also ask us to pay for a prescription drug you already bought; this is a request for a coverage decision about payment. To ask us to make a coverage decision, contact us by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. Please see the step-by-step instructions in your EOC in Chapter 9 Section 7.4.

If your health requires it, ask us to give you a "fast coverage decision." When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement. You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.) You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

Making an Appeal about medical coverage

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review, we give you our decision.

To start an appeal you, your doctor, or your representative must contact us. Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. If your health requires a quick response, you must call and ask for a "Fast appeal."

Our plan considers your appeal, and we give you our answer. When we are using the “fast deadlines,” we must give you our answer within 72 hours after we receive your appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

When we are using the standard deadlines, we must give you our answer on a request for a medical item or service within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer within 7 calendar days after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If our plan says no to your appeal for medical coverage, we are required to automatically send your appeal to the “Independent Review Organization.” The Independent Review Organization is an independent organization that is chosen by Medicare. Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The Independent Review Organization will tell you its decision in writing and explain the reasons for it. If your appeal is turned down and your case meets the requirements, you choose whether you want to take your appeal further. There are three additional levels in the appeals process. Please refer to your Evidence of Coverage (EOC) in Chapter 9, “*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*” for step-by-step instructions.

Making an Appeal about Part D prescription drugs

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review, we give you our decision.

To start an appeal you, your doctor, or your representative must contact us. Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal. If we do not give you a decision within 7 calendar days, we are required to send your request to be reviewed by an Independent Review Organization. If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your

appeal. If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal. If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request. If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request.

If you are making a “fast” appeal we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it. If we do not give you an answer within 72 hours, we are required to send your request on to be reviewed by an Independent Reivew Organization. If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor’s statement supporting your request.