FHCP Medicare Grievances, Coverage Decision and Appeals Overview

Grievances (Complaints)

Your right to make complaints

As a member of our plan, you have the right to make a complaint (also called "filing a grievance") for certain types of problems **not related to benefits, coverage or payment**. Here are some examples of problems that are handled through the grievance process:

- You are not satisfied with the quality of medical care you receive,
- you are unhappy with the cleanliness of one of our network pharmacies, doctor's offices or clinics,
- you experience excessive waiting times (for example, you have trouble getting a doctor's appointment or you have to wait too long in a doctor's office, at a pharmacy or to speak to a Member Services representative),
- you feel that someone did not respect your privacy rights, or
- you are dissatisfied with our timeliness in responding to coverage decisions and appeals you have asked for.

Filing a grievance with our plan

If you have a grievance related to our plan's medical care and services (Medicare Part C) or prescription drugs (Medicare Part D), we encourage you or your representative to call our Member Services Department first at 1-833-866-6559. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday – Friday. TTY users should call 1-800-955-8770. Calls to these numbers are free. We will try to resolve your complaint over the phone.

If we cannot resolve your grievance over the phone or you do not want to call our plan, we have a formal procedure to review grievances. These grievances must be submitted in writing to the following addresses or fax numbers:

For Part C Grievances (about your medical care and services) and Part D Grievances (about Part D prescription drugs):

Address: FHCP Medicare
Attention: Member Services
P.O. Box 9910
Daytona Beach, FL 32120

Fax Number: 1-386-676-7149

All grievances must be submitted within **60 days** after the event or incident. We will answer your grievance no later than **30 days** after we receive it (sooner if your health requires it). If we need more information and a delay is in your interest or you request a delay, we can take 14 more days (44 days total) to give you an answer.

Fast Grievances

If our plan denies your request for a "fast" coverage decision or a "fast" first-level appeal and you believe a longer waiting time could endanger your health, you may ask for a "fast" grievance (by phone or in writing). We will answer a "fast" complaint within **24 hours**.

Filing a grievance with your state's Quality Improvement Organization (QIO)
If you have a complaint about the quality of care you receive, you may file a grievance with your state's QIO. In Florida the QIO is called KEPRO. You may contact KEPRO at the following address or phone number:

Address: KEPRO
5201 W. Kennedy Boulevard, Suite 900
Tampa, FL 33609

Phone Number: 1-888-317-0751

Coverage Decisions
Coverage decisions are decisions we make about your benefits or coverage or about the amount we will pay for Part C medical services or Part D drugs. **A coverage decision about Part C medical services is called an "organization determination." A coverage decision about Part D drugs is called a "coverage determination."** Organization determinations and coverage determinations are the first step in addressing problems you may have regarding medical or prescription drug benefits, coverage or payment amounts.

Who may ask for a coverage decision?
You, your doctor/prescribing physician, or someone you name may ask us for a coverage determination. Other persons may be authorized under state law to act on your behalf.

Asking for a "standard" or "fast" coverage determination or organization determination
To ask for a "standard" or "fast" decision for a Part D drug or Part C medical care, you, your doctor or your representative should call, fax or write to us at the addresses and numbers listed below under Part D Coverage Determinations or Part C Organization Determinations.

Part D Coverage Determinations:

Address: FHCP Medicare
Attention: Member Services
P.O. Box 9910
Daytona Beach, FL 32120

Phone Number: 1-833-866-6559 (TTY users should call 1-800-955-8770). Calls to these numbers are free. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday – Friday.

Fax Number: 1-386-676-7149

Website: www.fhcpmedicare.com

Most standard coverage determination requests are requests for exceptions to our rules or restrictions that apply to a certain drug. These requests require that your doctor or other prescriber submit a written statement giving the medical reasons for requesting an exception to our rules or restrictions.

In these cases, we must give you our decision no later than 72 hours after we receive your doctor's or prescriber's statement supporting your request. For a standard coverage determination about a request for payment for a Part D drug you have already purchased, we must give you our decision no later than 14 days after we receive your request. If our decision is favorable, we must also make payment to you within 14 days after we received your request.

If these standard deadlines could cause serious harm to your health, you can ask for a "fast" or "expedited" coverage determination. If your doctor or other prescriber tells us you need a fast coverage determination, we will automatically agree to give you one. For a fast coverage determination about a Part D drug, we will give you our decision within 24 hours. This usually means 24 hours after we receive a written statement from your doctor or other prescriber supporting your request.

Part C Organization Determinations:

Address: FHCP Medicare
Attention: Member Services
P.O. Box 9910
Daytona Beach, FL 32120

Phone Number: 1-833-866-6559 (TTY users should call 1-800-955-8770). Calls to these numbers are free. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31 except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday – Friday.

Fax Number: 1-386-676-7149

For a standard organization determination, we must give you our decision within 14 days after we receive your request. However, we may take up to 14 additional days if you ask for more time or if we need more information to help us with our decision. We will let you know in writing if we need extra time to make our decision.

If the standard organization determination deadlines could result in serious harm to your health, you can ask us for a "fast" or "expedited" organization determination. If your doctor tells us you need a fast organization determination, we will give you one automatically. For a fast organization determination, we will answer your request within 72 hours. However, we may take up to 14 more days if you need more time to prepare for this review or we need additional information from you or your doctor.

Appeals

Appeals to our Plan (Appeal Level 1)
You may ask us to review our coverage determination (Part D) or organization determination (Part C), even if only part of our decision is not what you requested. An appeal to our plan about a Part D drug is also called a plan "redetermination." An appeal about a medical care decision is called a plan "reconsideration." When we review your appeal, we look carefully at the information about your request for an exception to Part D coverage rules or for coverage of medical care to ensure we were fair and that we followed all applicable rules when we made our initial decision.

Who may file your appeal of the coverage or organization determination?
When you appeal a coverage determination about a Part D drug or an organization determination for Part C medical care or services, you, your representative or your doctor may file a standard appeal request or a fast appeal request.

How soon must you file your appeal?
You must file the appeal request within 60 days from the date included on the notice of our coverage determination or organization determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

Asking for a standard appeal

To ask for a "standard" or "fast" appeal for a Part D drug or Part C medical care or services, you, your doctor or your representative should use the following contact information:

Part D Appeals (about Medicare Part D prescription drugs):

Address: FHCP Medicare
Attention: Member Services
P.O. Box 9910
Daytona Beach, FL 32120

Phone Number: 1-833-866-6559 (TTY users should call 1-800-955-8770). Calls to these numbers are free. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday – Friday.

Fax Number 1-386-676-7149

Website: www.fhcpmedicare.com

Part C Appeals (about medical care and services):

Address: FHCP Medicare
Attention: Member Services
P.O. Box 9910
Daytona Beach, FL 32120

Phone Number: 1-833-866-6559 (TTY users should call 1-800-955-8770). Calls to these numbers are free. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m. – 8:00 p.m. local time, Monday – Friday. (Only requests for fast appeals are accepted by telephone.)

Fax Number: 1-386-676-7149 (Only requests for fast appeals are accepted by fax.)

For standard Part D appeals, we must inform you of our decision within 7 days after receiving your appeal (sooner if your health requires a faster decision). If we fail to do so, we must send your appeal to Level 2 in the appeals process.

For fast and standard Part D appeals, if we deny your Level 1 appeal to our plan, you may choose to accept the denial, or you may make another appeal. This appeal would be a Level 2 appeal. At this level an outside Independent Review Organization with no connection to our plan reviews our decision and decides whether to uphold it or change it.

Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug or Part C medical care or services you have not received yet, you and/or your doctor will need to decide if you need a fast (or "expedited") appeal. The requirements for receiving a fast appeal are the same as those for receiving a fast coverage decision. If your doctor provides a written or oral statement explaining your need for a fast appeal, we will automatically give you one.

For Part C and Part D fast appeals, we must give you our decision within 72 hours after receiving your appeal. For Part C appeals only, we may take up to 14 more days if you request more time or if we

need more information to make our decision. If we do not meet these guidelines, we must send your appeal to Appeal Level 2. To request a fast appeal outside of regular business hours, please fax your request to the fax numbers shown in the “Asking for a standard appeal” section above.

Additional appeal rights
Provided you meet certain rules, you may be able to continue up to 5 levels of appeal. Please see our plan’s Evidence of Coverage for more information about these additional appeal levels. You also have appeal rights if you believe you are being released from a hospital too soon or you believe coverage for home health, skilled nursing or outpatient rehabilitation care is ending too soon. The Evidence of Coverage also has information about these types of appeals.

- FHCP Medicare is a Medicare Advantage organization with a Medicare contract.
- A Medicare-approved Part D Sponsor.
- Individuals must have both Medicare Part A and Part B to enroll.
- For FHCP Medicare: You must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor FHCP Medicare will be responsible for the costs.

This information is available for free in other languages. Please contact our Member Services number at 1-833-866-6559 for additional information. TTY users should call 1-800-955-8770. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open from 8:00 a.m.– 8:00 p.m. local time, Monday – Friday. Member Services also has free language interpreter services available for non-English speakers.