OPTIMA COMMUNITY COMPLETE (HMO SNP)

HOW TO MAKE A COMPLAINT, REQUEST A COVERAGE DECISION, OR FILE AN APPEAL ABOUT COVERED MEDICARE PART C MEDICAL CARE AND SERVICES OR COVERED PART D PRESCRIPTION DRUGS

Optima Community Complete (HMO SNP) is a Coordinated Care Plan with a Medicare contract and a contract with the Virginia Medicaid Program. Enrollment in Optima Community Complete (HMO SNP) depends on contract renewal.

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TABLE OF CONTENTS

DEFINITIONS OF COMPLAINTS, COVERAGE DECISIONS AND APPEALS

A complaint (also known as a grievance) is a problem or concern you have about something such as:

- The service you receive from Optima Community Complete (HMO SNP) Member Services.
- You feel that you are being encouraged to leave (disenroll from) our Plan.
- We don't give you a decision within the required time frame or give you the required notices.
- We don't forward your case to the Independent Review Organization if we do not give you an appeal decision on time.
- The quality of the medical care or Part D prescription drugs you receive, including quality of care during a hospital stay.
- How long you have to wait on the phone, in the waiting room or the exam room, or for prescriptions to be filled.
- Getting doctor appointments when you need them or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, pharmacists or other staff.

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or prescription drugs. The following situations are coverage decision examples:

- Your network doctor recommends a procedure or piece of medical equipment or prescription drug that requires prior authorization from us. Optima Community Complete (HMO SNP) will review the request and determine if it is a covered benefit and medically necessary.
- You or your doctor contact us to ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or Part D prescription drug.
- You are not getting certain medical care or services you want, and you believe that this care is covered by Optima Community Complete (HMO SNP).
- We make a coverage decision whenever we decide what is covered and how much we pay.
- You ask us to pay for a medical service or prescription drug you have already received.
- You are being told that medical care you are getting will be reduced or stopped, and you believe that this could harm your health.

If we make a coverage decision and you are not satisfied with this decision, you can file **an appeal** of our decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

WHO MAY MAKE A COMPLAINT, REQUEST A COVERAGE DECISION OR FILE AN APPEAL?

You may file a complaint, request a coverage decision, or file an appeal for Part C medical care or services or Part D prescription drugs. If you need someone to act on your behalf for any of these processes, that person must either have legal authority to do so or be appointed as your designated representative. If someone has legal authority, such as a Durable Power of Attorney or is a court appointed guardian, etc., a copy of this legal document must be sent to us for this person to act on your behalf. You can also have a relative, friend, attorney, doctor, or someone else be appointed as your designated representative, both you and this person must complete, sign, date, and return the *Appointment of Representative (AOR) Form*. This form is available on this website at Optima Community Complete complaints, coverage decisions, and appeals.

(https://www.optimahealth.com/members/community-complete/complaints-coverage-decisions-and-appeals). You and this person can also sign and date a statement with all of the same information included on the AOR form and send it to us so this person has legal permission to be your appointed representative. Your doctor can request a coverage decision or a Level 1 Appeal on your behalf. You can also call Optima Community Complete (HMO SNP) Member Services at the phone number below and we will send this AOR form to you.

For **medical complaints** (also known as grievances), coverage decisions, and appeals, mail or fax the legal documents, completed and signed *Appointment of Representative* form or written notice as follows:

For complaints and appeals:

Optima Community Complete (HMO SNP)
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or
Toll-free Fax: 1-866-472-3920

For coverage decisions:

Optima Community Complete (HMO SNP)
Medical Care Services
4417 Corporation Lane
Virginia Beach, VA 23462
Toll-free Fax: 1-844-251-5977

For **prescription drug** complaints (also known as grievances), coverage decisions and appeals, mail or fax the legal documents, completed and signed *Appointment of Representative* form or written notice as follows:

For complaints:

OptumRx
Attn: Part D Grievances
P.O. Box 3410
Lisle, IL 60532-3410
Toll-free Fax: 1-877-239-4545

For coverage decisions:

OptumRx
c/o Prior Authorization Clinical Guidelines
P.O. Box 25183
Santa Ana, CA 92799
Toll-free Fax: 1-877-239-4565

For appeals:

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Toll-free Fax: 1-877-239-4545

THE VIRGINIA INSURANCE COUNSELING AND ASSISTANCE PROGRAM (VICAP)

There is a State Health Insurance Assistance Program (SHIP) in each state that gives free and unbiased health insurance assistance to Medicare beneficiaries. The SHIP program is funded by the Federal government. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). VICAP counselors can assist you with Medicare problems and questions such as: help you understand the different types of Medicare plans; file a complaint or an appeal; and/or help you straighten out problems with your Medicare bills. You can contact VICAP toll-free at 1-800-552-3402. TTY users can call VICAP at 711. To learn more about VICAP, visit their website at Virginia Insurance Counseling and Assistance Program (https://www.vda.virginia.gov/vicap.htm).

HOW TO MAKE A COMPLAINT ABOUT COVERED PART C MEDICAL CARE AND SERVICES

You can always speak to one of our Optima Community Complete (HMO SNP) Member Services Representatives about a complaint, coverage decision, or appeal. Member Services can be reached at 1-800-927-6048. TTY users can call the Virginia Relay Service at 1-800-828-1140 or 711.

Calls to these numbers are free. From October 1 through March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET. From April 1 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system

allows you to obtain information on many topics related to your plan. If you need more information, you can leave a message including your name, phone number, the time you called, and your questions. A Member Services Representative will return your call the next business day.

You can also call Medicare for help with a complaint, coverage decision, or an appeal as follows:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit the Medicare website Medicare Government website for complaints, coverage decisions, and appeals (https://www.medicare.gov).

Making a complaint

If you have a complaint, you or your representative should call or write to Optima Community Complete (HMO SNP) Member Services as soon as possible but at least within 60 days of the occurrence. If you call us, we will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we will thoroughly investigate your complaint and notify you once we complete our review. You can also send us a written complaint.

If you want to send us a written complaint or you called and were not satisfied, you can mail or fax your complaint to us at:

Optima Community Complete (HMO SNP)
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or Toll-free Fax: 1-866-472-3920

Making a Fast Complaint

You can file a fast complaint if:

- You asked for a fast coverage decision for a service or drug, and we decided to process it under our standard (non-expedited) time frame. We will give you a fast decision if you resubmit it with a supporting medical statement from your doctor.
- We said we need up to 14 more days to decide on your coverage decision or appeal for a service or drug.

Quality of Care Complaints and Complaints about Certain Medical Services You think are Ending too Soon

If you have a complaint about the quality of care you have received, if you think your hospital stay is ending too soon, or you think your home health care, skilled nursing facility or Comprehensive Outpatient Rehabilitation Center services are ending too soon, you can contact Livanta BFCC-QIO Program. This organization is a group of practicing doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. Livanta is an independent organization and is not connected with our plan. To file a complaint with Livanta, send it to:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 1-888-396-4646
TTY: 1-833-985-2660
Website: Livanta BFCC-QIO Program (www.livanta.com)

HOW TO REQUEST A COVERAGE DECISION FOR COVERED PART C MEDICAL CARE AND SERVICES

A coverage decision is a decision Optima Community Complete (HMO SNP) makes about your benefits and coverage or about the amount we will pay for your medical care and services. The decision we make to approve or disapprove a test your doctor wants you to have that requires prior authorization from us in advance is a coverage decision. 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.

Asking us to pay for a covered medical service you have already received is a type of coverage decision. The Optima Community Complete (HMO SNP) Evidence of Coverage has information on how to request that we pay you back for a covered medical service that you have already paid for and received.

To ask for a coverage decision for Part C medical care or service, you, your doctor, or your representative should call, fax or write to us at the following:

Optima Community Complete (HMO SNP)
Medical Care Services
4417 Corporation Lane
Virginia Beach, VA 23462
1-800-927-6048
TTY: Virginia Relay Service 1-800-828-1140 or 711
Fax: 757-552-8844 (local) or 1-844-251-5977 (toll-free)

Asking for a fast coverage decision

You may ask for a fast coverage decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.

If your 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.

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 decision, we will send you a letter that says if you get a doctor's support for a fast decision, we will automatically give you one. The letter will also tell you how to file a fast complaint. You have the right to file a fast complaint if you disagree with our decision to deny your request for a fast coverage decision. See the section on "Fast Complaints" earlier in this document for details. If we deny your request for a fast decision, we will give you a standard decision.

HOW TO FILE AN APPEAL ABOUT COVERED PART C MEDICAL CARE & SERVICES

If you do not agree with the coverage decision we made about your Part C Medical Services, you, your doctor, or representative may file an appeal with us. The appeal must be filed within 60 days from the date included on the letter about our coverage decision. We may give you more time if you have a good reason for missing the deadline.

To file a standard appeal about Part C medical care or services, send or fax a signed, written appeal to:

Optima Community Complete (HMO SNP)
Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232 or Toll-free fax: 1-866-472-3920

Filing a fast appeal

If you want to appeal a decision we made about giving you Part C medical care or services that you have not received yet, you, your doctor or your representative can decide if you need to file a fast appeal. You can file a fast appeal by calling, faxing, or writing us at:

Optima Community Complete (HMO SNP)
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Phone: 757-687-6404 or Toll-free Phone: 1-800-927-6048
TTY: Virginia Relay Service at 1-800-828-1140 or 711
Fax: 757-687-6232 or Toll-free Fax: 1-866-472-3920

You can also file a fast appeal for Part C medical care or services outside of regular weekday business hours. Please call the Optima Health Appeals Department at 757-687-6404 and leave a detailed message. Your call will receive priority attention the next business day. Be sure to ask for a "fast" or "72-hour" decision.

If your doctor provides a written or oral supporting statement explaining that you need a fast appeal due to your health, we will automatically give you a fast decision. If you file a fast appeal 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 appeal, we will send you a letter informing you that if you get a doctor's support for a fast appeal, we will automatically give you a fast decision.

HOW TO MAKE A COMPLAINT ABOUT COVERED PART D PRESCRIPTION DRUGS

If you have a complaint about Part D prescription drugs, please call OptumRx. Optima Medicare contracts with OptumRx for your Part D drug coverage. You can call OptumRx toll-free at 1-866-603-7514, 24 hours a day, 7 days a week. TTY users can call 711.

You can also call Medicare for help with a complaint, coverage decision, or an appeal as follows:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit the Medicare website Medicare Government website for complaints, coverage decisions, and appeals (https://www.medicare.gov/).

Making a complaint

If you have a complaint, you or your representative should call or write to OptumRx as soon as possible but at least within 60 days of the occurrence. If you call OptumRx, they will try to resolve your complaint over the phone. If OptumRx cannot resolve your complaint over the phone, they will thoroughly investigate your complaint and notify you once they complete their review. You can also send a written complaint to OptumRx at the address or fax number below:

OptumRx
Attn: Part D Grievances
P.O. Box 3410
Lisle, IL 60532-3410
Toll-free Fax: 1-877-239-4545

Making a Fast Complaint

You can file a fast complaint if:

- You asked for a fast coverage decision for a drug, and we decided to process it under our standard (non-expedited) time frame. We will give you a fast decision if you resubmit it with a supporting medical statement from your doctor.
- We said we need up to 14 more days to decide on your coverage decision or appeal for a drug.

HOW TO REQUEST A COVERAGE DECISION FOR COVERED PART D PRESCRIPTION DRUGS

A coverage decision is a decision Optima Community Complete (HMO SNP) makes about your benefits and coverage or about the amount we will pay for your Part D drugs. If you want to know if we will cover a Part D drug before you receive it, you can ask us to make a coverage decision.

Asking us to pay for a prescription drug you have already received is a type of coverage decision. The Optima Community Complete (HMO SNP) Evidence of Coverage has information on how to request that we pay you back for a covered Part D drug that you have already paid for and received.

An exception is a type of coverage decision involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in different situations.

- You may ask us to cover a Part D drug even if it is not on our formulary (drug list).
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example:
  - For certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more.
  - Since you must receive prior authorization from us before you can get certain covered drugs, you can ask us to waive this requirement.
  - You could ask us to waive the step therapy requirement for a certain drug. This means you wouldn’t have to try a proven, less expensive drug before using a more expensive one.
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our fourth tier, the non-preferred brand Part D drug tier, you may ask us to cover it at the copay amount for drugs in the third tier, the preferred brand Part D drug tier instead. This would lower the copay amount you pay for your Part D drug. This is a request for a "tiering exception.”

Your doctor must submit a statement supporting your exception request. To help us make a decision more quickly, the medical information from your doctor should be sent to us with the exception request. If we approve your exception request, our approval is valid for the rest of the Plan calendar year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the copay amount we require you to pay for the drug.

To ask for a standard coverage decision for a Part D drug, you, your doctor, or your representative can call (24-hours a day, 7 day https://www.optimahealth.com/plans/community-complete/s a week), fax, or send OptumRx a written request or the completed form located on our website at Optima Community Complete complaints, coverage decisions, and appeals (https://www.optimahealth.com/plans/community-complete/). You can call Optima Community Complete (HMO SNP) Member Services (contact information is on page 2 of this document) and we will send this form to you. Call, mail or fax your written request or the completed form to:

OptumRx
c/o Prior Authorization Clinical Guidelines
P.O. Box 25183
Santa Ana, CA 92799
Phone: 1-866-603-7514; TTY: 711 (24 hours a day/7 days a week)
Fax: 1-877-239-4565

Asking for a fast coverage decision

You may ask for a fast coverage decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. If your 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. You cannot get a fast decision if you are asking us to pay you back for a Part D drug that you already received.

HOW TO FILE AN APPEAL ABOUT COVERED PART D PRESCRIPTION DRUGS

If you do not agree with the coverage decision we made about your Part D drug, you may file an appeal. The appeal must be filed within 60 days from the date included on the letter about our coverage decision. We may give you more time if you have a good reason for missing the deadline.

To ask for a standard appeal about a Part D drug, send or fax a signed, written appeal to:

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Phone: 1-866-603-7514 / TTY: 711 (24 hours a day/7 days a week)
Fax: 1-877-239-4545

Filing a fast appeal

If you want to appeal a decision we made about giving you a Part D drug that you have not received yet, you or your doctor need to decide if you need a fast appeal. You, your doctor, or your representative may file a fast appeal by calling, faxing, or writing:

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Phone: 1-866-603-7514 / TTY: 711 (24 hours a day/7 days a week)
Fax: 1-877-239-4545

If your doctor provides a written or oral statement explaining that you need a fast appeal due to your health, we will automatically give you a fast appeal. If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we decide that your medical condition does not meet the requirements for a fast appeal, we will send you a letter informing you that if you get a doctor's support for a fast appeal, we will give you one.

FOR MORE INFORMATION

You can find more information about any of these processes in the Evidence of Coverage (EOC) for your Optima Community Complete (HMO SNP) Plan. The EOC also includes additional appeal steps that can be taken if you are not satisfied with the result of your appeal with Optima Community Complete (HMO SNP).

You can go to the official U.S. Government site for Medicare to learn more about complaints and appeals. This website is Medicare Government website for complaints and appeals (https://www.medicare.gov/). In addition, you can call Medicare to file a complaint or appeal about your Medicare plan 24 hours a day/7 days a week at 1-800-MEDICARE. TTY/TDD users can call 1-877-486-2048.