What do I do if I have a complaint?

Our Members are very important to SOLIS Health Plans (HMO). We work hard to ensure all our members are satisfied with us. If you have any issues, calling our Member Services department is the first step. Member Services will assist you and let you know if you need to do anything else. You can call our Member Services department at 1-844-447-6547,TTY 711, from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30. If you do not wish to call, you can submit your complaint in writing and send it to us. You can also download a Grievance & Appeal Form to submit your complaint from our website at **www.solishealthplans.com.**You may submit your written Grievance and/or Appeal request to the SOLIS Grievance & Appeals department at the following address or fax number:

SOLIS Health Plans
PO Box 524173
Miami, FL 33152
Fax Number 1-833-615-9263

GRIEVANCES

A Grievance is a complaint or dispute that expresses dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers.

Some examples of why you or your authorized representative might file a grievance include the following:

- Benefit design (copays);
- Difficulty getting an appointment or having a long wait time for an appointment;
- Disrespectful or rude behavior by doctors, nurses, pharmacist or other plan clinic, hospital staff and plan staff;
- Failure to provide you a decision within the required time frame;
- Issues/concerns with the services you received;
- Issues/concerns with the medical care you received;
- If you believe our notices and other written materials are hard to understand.

You may request an expedited grievance if:

- We deny your request for an expedited organization/coverage determination;
- We deny your request for an expedited reconsideration/Part C appeal and/or redetermination/Part D appeal;
- You disagree with our decision to extend the timeframe to make an initial organization/coverage determination or expedited reconsideration/Part C appeal and/or redetermination/Part D appeal.

When filing a written grievance, please provide the following information: Your name, address, member identification number (listed on your Member ID card), your signature or that of your authorized representative, date, summary of the issue, any previous contact with us, and a statement of action requested.

You or your authorized representative may file a grievance with SOLIS Health Plans orally or in writing no later than 60 days after the occurrence. If you or your authorized representative require help in preparing and submitting your written grievance, please contact the SOLIS Member Services department and a Member Services Representative will help you.

SOLIS Health Plans will notify you or your authorized representative of the decision about your grievance as quickly as your case requires based on your health status, but not later than 30 calendar days after receiving your complaint. In some cases, 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. We will notify you of our decision about an expedited Grievance within 24 hours.

RECONSIDERATION/APPEALS (PART C)

An appeal is the action you or your authorized representative can take if you disagree with a decision SOLIS Health Plans has made on an Organization Determination. When we have completed the review, we will provide you our decision.

There are five successive levels to the appeals process:

- Level 1: Reconsideration by the health plan.
- Level 2: Review by the Independent Review Entity (IRE).
- Level 3: Hearing by an Administrative Law Judge (ALJ).
- Level 4: Review by the Medicare Appeals Council (MAC).
- Level 5: Review by a Federal District Court.

A decision may be appealed to the next level of appeal when the lower appeal entity issues a decision that is unfavorable to the member. Each unfavorable decision letter will provide instructions on how to move to the next level of appeal.

You or your authorized representative can request a first level appeal by requesting SOLIS Health Plans review an unfavorable organization decision. Reconsideration/appeal requests must be filed with the health plan within 60 calendar days from the date of the notice of the organization determination decision letter. You may file an expedited reconsideration requests orally or in writing. Standard reconsideration requests must be made in writing.

You may also contact our Member Services department to request a Grievance and Appeal form. You can also download a Grievance and Appeal Form from our website at **www.solishealthplans.com.**

If you or your legal representative requires assistance in preparing and submitting your written Reconsideration request, please contact the SOLIS Member Services department and a Member Services Representative will assist you.

Once the request is received by SOLIS Health Plans, we will decide and provide notice of our decision as quickly as your health requires, but no later than 72 hours for expedited requests, 30 calendar days for (Pre-Service) standard requests, or 60 calendar days for (Claim denial) requests. If the decision is unfavorable, you or your authorized representative can request further review.

After the first level of appeal, all following levels of appeal will be reviewed by an entity that is contracted with the Medicare Program, or the federal court system. This will help ensure a fair and impartial decision.

REDETERMINATIONS/APPEALS (PART D)

An appeal is the action you or your authorized representative can take if you disagree with a decision SOLIS Health Plans has made on a Coverage Determination. When we have completed the review, we will provide you our decision.

There are five successive levels to the appeals process:

- Level 1: Reconsideration by the health plan.
- Level 2: Review by the Independent Review Entity (IRE).
- Level 3: Hearing by an Administrative Law Judge (ALJ).
- Level 4: Review by the Medicare Appeals Council (MAC).
- Level 5: Review by a Federal District Court.

A decision may be appealed to the next level of appeal when the lower appeal entity issues a decision that is unfavorable to the member. Each unfavorable decision letter will provide instructions on how to move to the next level of appeal.

You or your authorized representative can go on to the first level of appeal by requesting SOLIS Health Plans to review the unfavorable coverage determination decision. Redetermination/appeal requests must be filed with the health plan within 60 calendar days from the date of the notice of the coverage determination decision letter. You may file an expedited redetermination requests orally or in writing. Standard redetermination requests must be made in writing.

When filing a written Redetermination (Part D Appeal), please provide the following information: You should include your name, address, member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

You may also contact our Member Services department to request a Redetermination Request Form. The Redetermination Request Form is also available for download on our website at **www.solishealthplans.com.**

If you or your legal representative requires assistance in preparing and submitting your written Redetermination request, please contact the SOLIS Member Services department and a Member Services Representative will assist you.

Once the request is received by SOLIS Health Plans, we will decide and provide notice of our decision as quickly as your health requires, but no later than 72 hours for expedited requests, or 7 calendar days for standard requests. If the decision is unfavorable, you or your authorized representative can request for further review.

After the first level of appeal, all following levels of appeal will be reviewed by an entity that is contracted with the Medicare Program, or the federal court system. This will help ensure a fair and impartial decision.

SOLIS Health Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in SOLIS depends on contract renewal.