

About your

Health Plan



How to make a complaint or file an appeal

What is a complaint?

A complaint is a way to tell us you are not satisfied about any matter other than an action. Another word for complaint is grievance. A complaint does not involve payment or coverage. A complaint may include the following:

- You are not satisfied with quality of care or services
- You feel your rights have not been respected
- You are not satisfied with us or one of our plan providers. Or you are not satisfied with the quality of your care

Making a complaint

Complaints may be made on the phone or in writing. The complaint must be made within 90 days after you have had the problem.

On the phone: If you call about your complaint, we may be able to give you an answer during the same phone call. If we can't answer you right away, we will answer as quickly as is required, based on your health, but no later than 10 days after you call. The time for us to respond to you may be extended for up to 14 days if you or your doctor requests more time or if we need more information and the delay is in your best interest. If you are not satisfied with the answer, you may then submit your complaint in writing. We can help you with this process. You may also contact the DHS Ombudsman Office at **(651) 431-2660**, toll free **1-800-657-3729**, or the Minnesota Department of Health at **(651) 201-5100**, toll free **1-800-657-3916**, TTY **(651) 201-5797**, for further assistance.

In writing: You, your doctor or your representative (with your written consent) may make your complaint in writing. Use the address below. You may also contact the DHS Ombudsman Office at **(651) 431-2660**, toll free **1-800-657-3729**, or the Minnesota Department of Health at **(651) 201-5100**, toll free **1-800-657-3916**, TTY **(651) 201-5797**, for further assistance.

Within 10 days of receiving your complaint, we will send you a letter telling you we've received it. The letter may include the decision if a decision is made within 10 days. If we don't make a decision within 10 days, we will make a decision within 30 days from the day we receive your complaint. The time for responding to you may be extended for up to 14 days if you or your doctor asks for more time, or if we need more information and the delay is in your best interest.

Blue Plus address for written complaints:

Consumer Service Center P3-2
Blue Plus
P.O. Box 64179
Saint Paul, MN 55164
Fax (651) 662-2745

You also have the right to ask for a faster decision, called an "expedited grievance." We will respond to you within 24 hours if you do not agree with our decision:

- To not provide a faster initial decision (organization determination or coverage determination) or an expedited appeal, or
- To take more time to make an initial decision for medical care or a decision for an appeal regarding the denial of coverage for a medical service

What is an organization determination?

An organization determination is a decision we make about whether we will cover the medical care or services you are requesting or whether we will pay for the medical care or services you already received. You can also contact the plan and ask for an organization determination. For example, if you want to know if we will cover a service before you receive it, you can ask us to make an organization determination for you.

What is a coverage determination?

A coverage determination is also a decision we make about whether a prescribed drug is covered by the plan. If you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered, that is not a coverage determination. You will need to call or write to us to ask for a decision about the coverage if you disagree.

What is an exception?

An exception is a type of coverage determination that, if approved, lets you get a drug that is not on the formulary (a formulary exception), or get a nonpreferred drug. You may also ask for an exception:

- If we require you to try another drug before receiving the drug you are requesting, or
- If the plan limits the quantity or dosage of the drug you are requesting

What is an appeal?

An appeal is what you do if you disagree with a decision to deny a health care service or prescription drug or payment for services or drugs you already received. You may also appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item or service you think you should get.

You can write to the Minnesota Department of Human Services to request a State Fair Hearing

(SFH). You may request a SFH at any time during the Plan's appeal process. You do not have to file an appeal with the Plan before you request a SFH.

Making an appeal

Appeals may be made on the phone or in writing and must be made within 90 days of our notice to you. If you choose to appeal through the Medicare process, you must make your appeal within 60 days.

You, your doctor or your representative (with your written consent) may make an appeal. Within 10 days of receiving your appeal, we will send you a letter telling you we've received it.

If you call about your appeal, we will send you a letter along with a form that you will need to sign and send back to us. The letter may include the decision if we make a decision within 10 days. If we don't make a decision within 10 days, under Medicaid, we will make a decision within 30 days from the date we receive your appeal. Under Medicare, we will make a decision within 30 days for services you have not already received and 60 days for services already received from the date we receive your appeal. The time for responding to you may be extended for up to 14 days if you ask for more time or if we need more information and if the delay is in your best interest. We will send you a letter if we need to use this 14-day extension.

Faster appeals

An appeal may be decided faster (expedited) if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a faster appeal no later than 72 hours after we receive it. We may extend this time by up to 14 days if you ask for an extension, or if we need additional information and if the extension benefits you. If we do not agree that the service is urgently needed, we will tell you within 24 hours. If you disagree, you may file a complaint with us or request a State Fair Hearing. If your doctor asks for a faster appeal for

you, or supports you in asking for one, and the doctor says that waiting for 30 days could seriously harm your health, we will automatically do a faster appeal. If you ask for a faster appeal without support from a doctor, we will decide if your health requires a faster appeal. If it does not, we will make a decision within the standard time for appeals.

What happens after you appeal?

If any of the services or payments is still denied, you or your representative can ask for a State Fair Hearing with the Minnesota Department of Human Services. For a Medicare covered service, Medicare will provide a new and impartial review of your case by an Independent Review Entity (IRE) outside of the Blue Plus organization.

If you disagree with their decision, you have more appeal rights and will be notified of those rights.

Member services **(651) 662-6013** or toll free **1-888-740-6013**, 8 a.m. to 8 p.m. Central Time, seven days a week TTY/TDD **(651) 662-8700** or toll free **1-888-878-0137**

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການເປີດຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທສຕາມເລກໂທສທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

SecureBlue (HMO SNP) is offered in conjunction with the Minnesota Senior Health Options (MSHO) program. SecureBlue is a Special Needs Plan offered by Blue Plus, a health plan with a Medicare contract. This is a voluntary program. Drug coverage benefits are subject to limitations.

Participation in the SecureBlue program is limited to beneficiaries who are 65 or older, receive Medical Assistance (Medicaid) with both Medicare Part A and Part B, and live in the service area.

This information is available in other forms to people with disabilities by calling Blue Plus member services at **(651) 662-6013**, **1-888-740-6013** (toll free), or **(651) 662-8700** or **1-888-878-0137** (TDD), or **7-1-1**, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, voice, ASCII, hearing carryover), or **1-877-627-3848** (speech-to-speech relay service).

You may also get information about Medicare health or Part D benefits and services at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY users call **1-877-486-2048**.)

