Part 13: How to resolve a problem with Healthy Blue

We care about the quality of service you get from our health care providers and us. If you have a problem with the level of service you receive, we would like to talk with you. Here are some of the issues we can help you with:

- Access to health care
- Care and treatment by a doctor
- Issues with how we do our business
- Any aspect of your care

Who may file a grievance or appeal

You can file a grievance or appeal with us. You can also choose someone to act on your behalf such as a relative, provider or an attorney.

If you aren't happy with Healthy Blue, you or a person you choose to act for you can:

- File a grievance with us if you're dissatisfied with the quality of service or care you received.
- File an appeal with us for a benefit that:
  - Has been denied.
  - Had a partial approval (this includes the type or level of the service).
  - Has been changed.
  - Has been stopped.
  - Has been approved then stopped.
- Ask for a State Fair Hearing after you get our final denial.

If you need help understanding the steps to file a grievance or appeal, or if you need help completing the forms, please call us at **1-866-781-5094 (TTY 1-866-773-9634)**. If you need an interpreter, we'll provide one at no cost to you.

Grievances

A grievance is when you tell us you're not happy about anything other than an adverse benefit determination. An adverse benefit determination means we:

- Deny or limit the type or level of service you ask for.
- Reduce, delay or end a service that was approved before.
- Deny a payment for service in whole or in part.
- Fail to provide services or resolve grievances and appeals in a timely manner.

- Deny a request to get services outside your network if you live in a rural area with only one managed care organization (MCO).
- Deny a request to dispute a financial liability, including cost sharing, copays, premiums, deductibles and coinsurance.

You or a person you choose to act for you can file a grievance with us. You may file a grievance if you:
- Aren't happy with us.
- Feel a provider or the health plan has discriminated against you.
- Aren't happy with the providers who work with us.

To file a grievance, you or the person you choose to act for you can:
- Call us at the Customer Care Center (CCC) number on the bottom of this page.
- Fill out a grievance form and send it to us. You can find grievance forms on our website at **www.HealthyBlueSC.com**. It's called the **Member Grievance Form**.
- Write a letter and send it to us.

You may file a grievance at any time. Tell us:
- Who is involved in the grievance.
- What happened.
- When it happened.
- Where it happened.
- Why you are not happy with your health care services.

Attach any papers you think will help us look into your issue. Our CCC staff can help you file a grievance. After you are done filling out the form or letter, mail it to:

Healthy Blue, BlueChoice HealthPlan of South Carolina
Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

If you can't mail the form or letter, you or the person you choose to represent you can call our CCC number at the bottom of the page.

If you (or the person you choose) calls into the Customer Care Center (CCC) and files a grievance by phone, the grievance will be verbally acknowledged. The CCC associate will resolve the verbal grievance during the live call or no later than the end of the next business day by contacting you (or the person you choose) and providing a verbal resolution. If the CCC is unable to resolve the verbal grievance during the live call or by the end of the next business day, the Grievance and Appeals Department will be responsible to resolve the grievance.

After we receive your grievance by phone or in the mail, we'll tell you we received it by:

Customer Care Center (CCC): 1-866-781-5094 (TTY 1-866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 1-866-577-9710 (TTY 1-800-368-4424) 24 hours a day, seven days a week

- Calling you (if your grievance can be resolved in one business day).
- Sending you an **Acknowledgement Letter** within five calendar days (if we need more than one business day to resolve your grievance).
- If your grievance deals with a medically urgent issue, we'll resolve your grievance within 14 calendar days of when we receive it.

We'll send you a **Grievance Resolution Letter** within 90 calendar days of the date we got your grievance. This letter will:

- Describe your grievance.
- Tell you what has been done to solve your problem.

Healthy Blue may take an extra 14 calendar days if:

- You ask for an extension to resolve your grievance.
- We need more information and time to make a decision.
- The extension is in the member's best interest.

If you don't ask for extra time, we'll send you a written notice. It will let you know why we want the extension and your right to file a grievance if you don't agree with the decision.

For grievances about discrimination, you or your representative may also file a complaint of discrimination in court or with the U.S. Department of Health and Human Services Office for Civil Rights on the basis of:

- Race
- Color
- National origin
- Sex
- Age
- Disability

You can file a discrimination complaint:

- Electronically through the Office for Civil Rights Complaint Portal at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Ave. SW, Room 509F, HHH Building
  Washington, DC 20201

You or your representative can get the complaint form at **www.hhs.gov/ocr/office/file/index.html*.** You must file the form with the Office for Civil Rights within 180 days of the date of the alleged discrimination.

Customer Care Center (CCC): 1-866-781-5094 (TTY 1-866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 1-866-577-9710 (TTY 1-800-368-4424) 24 hours a day, seven days a week

Appeals

You or the person you choose to act for you can ask for an appeal. This person can be anyone you choose, including an attorney. You can ask for an appeal if you get an adverse benefit determination notice letter from us saying coverage for a medical service:

- Was denied.
- Was changed.
- Was approved then stopped.
- Was not given in a timely manner.

You can also ask for an appeal if you receive an adverse benefit determination saying we denied your request to dispute financial liabilities like:

- Copays
- Premiums
- Deductibles
- Coinsurance

You must ask for an appeal within 60 calendar days from the date on your adverse benefit determination notice. To ask for an appeal:

- Call us at **1-866-902-1689**.
- Fill out a **Member Appeal Request Form** and send it to us. You can find appeal forms at the places where you get care, such as your doctor's office, or on our website.
- Write a letter and send it to us at:
  Healthy Blue, BlueChoice HealthPlan of South Carolina
  Grievance and Appeals Department
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Fax: 1-866-216-3482

If someone acting on your behalf sends an appeal for you, you are required to sign a **Member Appeal Representative Form**. You may get a **Member Appeal Representative Form** by calling the CCC number at the bottom of this page. When you call us, give your OK for someone to act on your behalf. We'll send you the **Member Appeal Representative Form** for you to sign and return to us. We may also ask you to sign a release form if we need to request your medical records to consider your appeal.

The CCC can help you file your appeal. If you call to tell us about your appeal, you must send us a written appeal signed by you or the person you choose to act for you. If you call and ask for an expedited appeal, you don't need to send a signed written appeal to us.

A parent, legal guardian or conservator may file a grievance or appeal for a member who is:

- A minor.
- Incompetent (not able to act for mental reasons).

Customer Care Center (CCC): 1-866-781-5094 (TTY 1-866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 1-866-577-9710 (TTY 1-800-368-4424) 24 hours a day, seven days a week

- Incapacitated (not able to act for physical reasons).

We'll send you an **Acknowledgment Letter** within five calendar days. It will tell you we got your appeal request. We'll resolve your appeal within 30 calendar days. We'll send you an adverse benefit determination notice that tells you our decision on your appeal. This letter will have:

- The date we made the decision.
- The specific reason why we made the decision.

Expedited (rush) appeals

You can ask for an expedited (rush) appeal if you think waiting 30 calendar days for our decision may harm your health. When you ask for a rush appeal, be sure to tell us that you think waiting 30 calendar days will harm your health and why.

A medical director will review your request for a rush appeal. If the medical director thinks waiting 30 calendar days will harm your health, we'll:

- Tell you our decision within 72 hours.
- Send our decision to you on the same day we make it.

If the medical director thinks waiting 30 calendar days won't harm your health, we'll send you a letter within two calendar days. The letter will let you know we'll complete your appeal as quickly as we can within 30 calendar days. We'll also call you to tell you what we decide.

For all appeals

You or a person you choose to act for you, including your attorney, can ask to add up to 14 calendar days to your appeal time. You should ask to extend your appeal time if you need to send us more information about your appeal.

We also may add up to 14 calendar days to your appeal time if it's in your best interest to do so. We'll call you and send a letter within two calendar days to tell you or your representative:

- The reason for the delay.
- You may file a grievance within two calendar days if you disagree with our decision to extend the review.

You have the right to file a grievance if you don't agree with our extension decision. We will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

You or the person you choose to act for you can look at and ask to see your case file before or during the appeal process. Your case file includes medical records or other papers that are taken into account during your appeal. During your appeal, you or the person you choose to act for you can also:

- Show proof of what you say or claim.

- Show this proof in person or in writing.

You can ask us for a copy of what we used to make our decision. This includes:

- The benefit terms.
- Guidelines.
- Rules.
- Other reasons for our decision.

If your doctor wants to speak with the doctor reviewing your appeal, they can call our Utilization Management (UM) department at **1-866-902-1689, ext. 7979**.

You may keep your benefits for the appealed service while we review your appeal if all of these happen:

- You ask for the appeal within 10 calendar days from the date on your adverse benefit determination notice, or the intended effective date of the plan's proposed adverse benefit determination.
- The appeal has to do with coverage for a service that has been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- An approved provider ordered the service.
- The original period covered by the original authorization has not expired.
- You asked to extend your benefits.

They will be in effect until one of these happens:

- You stop your appeal request.
- Ten days have passed after we sent you a **Notice of Action** letter with our decision to uphold the first denial (unless you asked for a State Fair Hearing within that 10-day period).
- A State Fair Hearing officer upholds our denial.
- The time frame of an approved service has been met.

If the result of the appeal is the same as the original denial decision, you may have to pay for the costs of the services you were given while the appeal was pending.

Appealing a coverage decision

We may review some of the care your doctor says you need. We also may ask your doctor why you need a certain service. If we say "no" to paying for a service your doctor asks for, we'll send you and your doctor a letter explaining why. This letter will also tell you how to appeal.

You or your doctor may appeal if we say "no" to a medical service or if we don't pay for a medical service. To learn more, please give us a call.

State Fair Hearing

If you aren't happy with our response to your appeal, you or the person you choose to act for you has the right to ask for a State Fair Hearing with the South Carolina Department of Health and Human Services (SCDHHS) Division of Appeals and Hearings. The person you choose to act for you can be anyone, including a relative, provider or an attorney.

You must ask for a State Fair Hearing within 120 calendar days from the date of the **Notice of Resolution** letter. To ask for a State Fair Hearing, you or the person you choose to act for you can:

- Send a written request to:
  Division of Appeals and Hearings
  1801 Main St.
  P.O. Box 8206
  Columbia, SC 29202
  803.898.2600 OR 800.763.9087
  Fax: 803.255.8206
  appeals@scdhhs.gov

Visit www.scdhhs.gov/appeals*. To learn more about State Fair Hearings, please call 1-800-763-9087.

You may keep your benefits for the appealed service while you wait for your hearing if all of these happen:

- You ask for the hearing within 10 calendar days from the date you get the adverse benefit determination notice.
- The hearing has to do with coverage for a service that has been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- An approved provider ordered the service.
- The original period covered by the original authorization has not expired.
- You asked to extend your benefits.

You'll be able to keep them until one of these happens:

- You stop your hearing request.
- A State Fair Hearing officer upholds our denial.
- The time frame of an approved service has been met.

If the result of the hearing is the same as the original denial decision, you may have to pay for the costs of the services you were given while the appeal was pending.

*These links lead to third-party websites. Those companies are solely responsible for the privacy policies and content on their site.