



The Essence of Care

## APPEALS and GRIEVANCES (Including FORMULARY EXCEPTIONS)

### YOUR RIGHT TO MAKE COMPLAINTS

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “**Appeals**” and “**grievances**” are the two different types of complaints you can make. Which one you make depends on your situation.

### WHEN TO USE THE APPEALS PROCESS?

An “**appeal**” is the type of complaint you make when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit (including Part D services and benefits).

You can file an appeal if:

- We refuse to cover or pay for services you think we should cover
- We or one of our plan providers refuses to give you a service you think should be covered
- We or one of our plan providers reduces or cuts back on services or benefits you have been receiving
- You think we are stopping your coverage of a service or benefit too soon

You can submit an appeal within sixty (60) days of the initial denial date.

### HOW QUICKLY WE DECIDE ON YOUR APPEAL DEPENDS ON THE REASON FOR THE APPEAL:

- For a decision about payment for medical care you already received, we have sixty (60) calendar days to make a decision after we receive your appeal.
- For a standard decision about medical care we have thirty (30) calendar days to make a decision, but will make it sooner if your health condition requires it. However, if you ask for more time, or if we find that helpful information is missing, we can take up to fourteen (14) more days to make our decision after we receive your appeal,
- For a decision about payment for Part D prescription drugs you already received, we have up to seven (7) calendar days to make a decision after we receive your appeal. If we find in your favor, we have thirty (30) days from the date of your request to issue payment.
- For a standard decision about Part D prescription drugs we have up to seven (7) calendar days to make a decision after we receive your appeal, but will make it sooner if your health condition requires it..

In addition, you, any doctor, or your authorized representative can ask us to give a “quick” (expedited) decision (rather than a “standard” decision) about medical care or Part D prescription drug coverage that you have not already received. If we give you an “expedited” decision, we must make our determination within seventy-two (72) hours for a decision about medical care or Part D prescription drugs.

**FOR COMPLETE DETAILS ON THIS PROCESS, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE or visit [www.fidelissc.com](http://www.fidelissc.com).**

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A Coordinated Care plan with a Medicare Advantage contract  
and a contract with the Michigan Medicaid program

## WHEN TO USE THE **GRIEVANCE** PROCESS

A “**grievance**” is the type of complaint you make if you have any other type of problem with Fidelis SecureCare or one of our plan providers. For example, you would file a grievance if you have a problem with things such as:

- the quality of your care,
- waiting times for appointments or in the waiting room,
- the way your doctors or others behave,
- being able to reach someone by phone or getting the information you need,
- or the cleanliness or condition of the doctor’s office.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than thirty (30) calendar days after receiving your complaint. We may extend the timeframe by up to fourteen (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.

You are also entitled to an **EXPEDITED REVIEW** of your grievance if you disagree with:

- Our decision to deny your request for an expedited review of a request for medical care
- Our decision to deny your request for an expedited review of an appeal of denied services
- Our decision that an extension is needed to review your request for medical care
- Our decision that an extension is needed to review your appeal of denied medical care

We will quickly review your request and notify you of our decision within twenty-four (24) hours of receiving your complaint.

## **TO SUBMIT GRIEVANCE**

### **For Medical Care or For Part D Prescription Drugs**

By Phone: (877) 372-8085 or TTY at (888) 844-5530

By Fax: (866) 542-0688

In Writing: Fidelis SecureCare  
Attention: Member Grievances  
20 N. Martingale Road, Suite 180  
Schaumburg, IL 60173

When you contact us, we will need to know your name and your ID number. We will also need to know the nature of the grievance and the date the grievance occurred. Be sure to provide your phone number (and address if you are submitting the grievance in writing) so we can notify you of our decision.

## **TO SUBMIT AN APPEAL**

### **For Medical Care**

By Phone: 877-372-8085 or TTY 888-844-5530

By Fax: 866-596-9218

In Writing: Fidelis SecureCare  
Attention: Member Appeals  
20 N. Martingale Road, Suite 180  
Schaumburg, IL 60173

## **TO SUBMIT AN APPEAL**

### **For Part D Prescription Drugs**

By Phone: 877-378-7948 or TTY 800-498-5428

By Fax: 866-308-6294 or 866-308-6296

In Writing: Part D Appeals  
MS CA 106-0286  
3515 Harbor Blvd.  
Costa Mesa, CA 92626

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