1300.68 Grievance System

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a)

The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (2) "Complaint" is the same as "grievance." (3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee. (4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority. (A) If the plan has multiple internal levels of grievance resolution or appeal, all levels

must be completed within 30 calendar days of the plan's receipt of the grievance. (B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422 , or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

(1)

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(2)

"Complaint" is the same as "grievance."

(3)

"Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(4)

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority. (A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance. (B)

Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422 , or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

(A)

If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

(B)

Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422 , or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

(b)

The plan's grievance system shall include the following: (1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures. (2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance

system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address. (3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation. (4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances. (5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented. (6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used. (7) Grievance forms and a description of the

grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request. (8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance. (9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.

(1)

An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(2)

Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.

(3)

The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other

communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

(4)

The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

(5)

A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

(6)

The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used.

(7)

Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

(8)

The plan shall assure that there is no discrimination against an enrollee or subscriber

(including cancellation of the contract) on the grounds that the complainant filed a grievance.

(9)

The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.

(c)

Through periodic medical surveys under Section 1380 of the Act, the Department shall periodically review the plan's grievance system, including the records of grievances received by the plan, and assess the effectiveness of the plan policies and actions taken in response to grievances.

(d)

The plan shall respond to grievances as follows:(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance. (2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance. (3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law. (4) For grievances involving

delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814. (5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review. (6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision. (7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone

number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act. (8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

(1)

A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

(2)

The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

(3)

The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of

the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4)

For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5)

Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

(6)

Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.

(7)

The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

(8)

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

(e)

The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall: (1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other

contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system;(2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system;(4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration. (2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and(4) complaints about access to care (including complaints about the waiting time for appointments), and(5) complaints about the quality of service, and (6) other issues.

(1)

Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system;(2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system;(4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration.

(1)

the plan's internal grievance system;

(2)

the Department's consumer complaint process;

(3)

the Department's Independent Medical Review system;

(4)

an action filed or before a trial or appellate court; or

(5)

other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration.

(1)

the Medicare review and appeal system;

(2)

the Medi-Cal fair hearing process; or

(3)

arbitration.

(2)

The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity,

(3)

complaints about the quality of care and

(4)

complaints about access to care (including complaints about the waiting time for appointments), and

(5)

complaints about the quality of service, and

(6)

other issues.

(f)

Quarterly Reports (1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter. (2) The quarterly report shall include: (A) The licensee's name, quarter and date of the report; (B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan; (C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process;(3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration. (D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3)

complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized. (E) The quarterly report shall not contain personal or confidential information with respect to any enrollee. (3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application. (4) The quarterly report shall be filed in the format specified in subsection (i).

(1)

All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

(2)

The quarterly report shall include: (A) The licensee's name, quarter and date of the report; (B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan; (C) A brief explanation of why the grievance was not resolved in 30 days, and

indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process;(3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration. (D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized. (E) The quarterly report shall not contain personal or confidential information with respect to any enrollee.

(A)

The licensee's name, quarter and date of the report;

(B)

The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan;

(C)

A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process;(3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration.

(1)

the plan's internal grievance system;

(2)

the Department's consumer complaint process;

(3)

the Department's Independent Medical Review system;

(4)

court; or

(5)

other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system;(2) the Medi-Cal fair hearing process; or(3) arbitration.

(1)

the Medicare review and appeal system;

(2)

the Medi-Cal fair hearing process; or

(3)

arbitration.

(D)

The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.

(E)

The quarterly report shall not contain personal or confidential information with respect to any enrollee.

(3)

The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application.

(4)

The quarterly report shall be filed in the format specified in subsection (i).

(g)

An enrollee may submit a grievance to the Department. The Department shall notify the plan, and within five (5) calendar days after notification, the plan shall provide the following information to the Department:(1) A written response to the issues raised by the grievance. (2) A copy of the plan's original response sent to the enrollee regarding the grievance. (3) A complete and legible copy of all medical records related to the grievance. The plan shall inform the Department if medical records were not used by the plan in resolving the grievance. (4) A copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the plan relied solely on the EOC, the plan shall notify the Department of that fact. (5) All other information used by the plan or relevant to the resolution of the grievance. (6) The Department may request additional information or medical records from the plan. Within five (5) calendar days of receipt of the Department's request, the plan shall forward information and records that are maintained by the plan or any contracting provider. If requested information cannot be timely forwarded to the Department, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected.

(1)

A written response to the issues raised by the grievance.

(2)

A copy of the plan's original response sent to the enrollee regarding the grievance.

(3)

A complete and legible copy of all medical records related to the grievance. The plan shall inform the Department if medical records were not used by the plan in resolving the grievance.

(4)

A copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the plan relied solely on the EOC, the plan shall notify the Department of that fact.

(5)

All other information used by the plan or relevant to the resolution of the grievance.

(6)

The Department may request additional information or medical records from the plan. Within five (5) calendar days of receipt of the Department's request, the plan shall forward information and records that are maintained by the plan or any contracting provider. If requested information cannot be timely forwarded to the Department, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected.

(h)

Nothing in this section shall preclude an enrollee from seeking assistance directly from the Department in cases involving an imminent or serious threat to the health of the enrollee or where the Department determines an earlier review is warranted. In such cases, the Department may require the plan and contracting

providers to expedite the delivery of information. The Department may consider the failure of a plan to timely provide the requested information as evidence in favor of the enrollee's position in the Department's review of grievances submitted under subsection (b) of Section 1368 of the Act.

(i)

STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE QUARTERLY REPORT OF PENDING AND UNRESOLVED GRIEVANCES PURSUANT TO HEALTH AND SAFETY CODE SECTION 1368(c) Name of Licensed Health Plan (as appearing on license): _____ DMHC Plan File No.: _____-_____ Report for _____Quarter 200 _____ Categories of Grievances Included in this Report: (Check and list current enrollment) [] Commercial [] Medicare [] Medi-Cal [] Healthy Families Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights. I. Total Number of Grievances Unresolved Within 30 Days During the Quarter NOTE: These include all grievances received by the plan or any entity to which the plan has delegated grievance resolution. TotalCommMedicareMedical

A. Total number of grievances pending or submitted over 30 days at the beginning of the quarter C. Total number of grievances that were unresolved within 30 days at any time during quarter (A + B) D. Total number of grievances pending or submitted over 30 days at the end of the quarter II. Commercial Members Number of Commercial Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service

1. Pending in Plan's Internal Grievance System 2. Pending in Department's consumer complaint process 3. Pending in Department's Independent Medical Review system 4. Submitted to Arbitration 5. Pending in Court 6. Pending, other dispute resolution Total III. Medicare Members (complete if Medicare + Choice products provided by Plan) Number of Medicare Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service 1. Pending in Plan's Internal Grievance System 2. Submitted to Medicare Appeals System 3. Pending in Department's consumer complaint process 4. Pending in Department's Independent Medical Review system 5. Submitted to Arbitration 6. Pending in Court 7. Pending other dispute resolution Total IV. Medi-Cal Members (Complete if Medi-Cal Managed Care products offered by Plan) Number of Medi-Cal Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service 1. Pending in Plan's Internal Grievance System 2. Submitted to Medi-Cal fair hearing process 3. Pending in Department's consumer complaint process 4. Pending in Department's Independent Medical Review system 5. Submitted to Arbitration 6. Pending in Court 7. Pending, other dispute resolution Total VERIFICATION I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true. BY:_____

(Signature of Individual Authorized to Sign on Behalf of Plan)

_____(Typed Name, Title, Phone)

I.

Total Number of Grievances Unresolved Within 30 Days During the Quarter NOTE: These include all grievances received by the plan or any entity to which the plan has delegated grievance resolution. TotalCommMedicareMedical A. Total number of grievances pending or submitted over 30 days at the beginning of the quarter C. Total number of grievances that were unresolved within 30 days at any time during quarter (A + B) D. Total number of grievances pending or submitted over 30 days at the end of the quarter

II.

Commercial Members Number of Commercial Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service 1. Pending in Plan's Internal Grievance System 2. Pending in Department's consumer complaint process 3. Pending in Department's Independent Medical Review system 4. Submitted to Arbitration 5. Pending in Court 6. Pending, other dispute resolution Total

III.

Medicare Members (complete if Medicare + Choice products provided by Plan) Number of Medicare Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service 1. Pending in Plan's Internal Grievance System 2. Submitted to Medicare Appeals System 3. Pending in Department's consumer complaint process 4. Pending in Department's Independent

Medical Review system 5. Submitted to Arbitration 6. Pending in Court 7. Pending other dispute resolution Total

IV.

Medi-Cal Members (Complete if Medi-Cal Managed Care products offered by Plan)

Number of Medi-Cal Member Grievances Unresolved Within 30 Days During the Quarter by Type of Grievance Reason Why Pending Over 30 DaysTotal, all grievance typesCoverage DisputesDisputes Involving Medical NecessityQuality of CareAccess to Care (including appointments)Quality of Service 1. Pending in Plan's Internal Grievance System 2. Submitted to Medi-Cal fair hearing process 3. Pending in Department's consumer complaint process 4. Pending in Department's Independent Medical Review system 5. Submitted to Arbitration 6. Pending in Court 7. Pending, other dispute resolution Total VERIFICATION I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true.

BY:_____ (Signature of Individual Authorized to Sign on Behalf of Plan) _____(Typed Name, Title, Phone)