Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

GRIEVANCES NOTIFICATION

Cox HealthPlans members have the right to file a Grievance and submit a request for a Second-level Review through a formal process. This notice addresses the identification, review and resolution of member Grievances and Second-level Reviews.

If you have any questions about your coverage, or are unhappy with the service from Cox HealthPlans or providers contracted with us, please call our Member Services Department at 1 (800) 205-7665, or access information by visiting www.coxhealthplans.com. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language line services interpreter. Our Member Service representatives are trained to make the connection to provide clear access to Benefits information.

GRIEVANCE PROCEDURE

DEFINITIONS

A complaint is any expression of concern about a condition in the Plan's operation. A complaint may be initiated in person, in writing, or by telephone to the Member Services Department.

A Grievance is a written complaint submitted by or on behalf of a Member regarding the:

- Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Member and a health carrier.
- A request for a standard or expedited internal review of an adverse benefit determination involving a recission of coverage.

A complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to Cox HealthPlans.

A Covered Person may file a Grievance when he feels Cox HealthPlans has not adequately responded to his needs.

PROCEDURES FOR COMPLAINTS:

Covered Persons with complaints, suggestions, or problems regarding any aspect of services rendered by a Cox Health Systems Insurance Company Provider, or relationships with that Provider should contact the Provider with whom the problem occurred. If the matter is not satisfactorily resolved, the Covered Person may make an informal complaint by contacting Cox Health Systems Insurance Company Member Services Department.

If the informal complaint is not with a particular Provider but is with the administrative operations of Cox Health Systems Insurance Company itself, the Member Services Department should be contacted directly.

The Covered Person has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time for assistance by mail at P.O. Box 690, Jefferson City, MO 65101; or by phone at (800) 726-7390 or (573) 751-2640.

PROCEDURES FOR FORMAL GRIEVANCES:

Cox HealthPlans has a first-level and second-level Grievance review process. A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person, may submit a Grievance.

A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person, has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding an external review of a Grievance. Neither a first-level or second-level Grievance is required prior to a Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person contacting the Missouri Department of Commerce & Insurance.

First Level Grievance

First-level Grievance reviews must be submitted within 180 days from receipt of a notification of an adverse benefit determination.

Upon receipt of a request for first-level Grievance review, the Plan will:

1. Acknowledge receipt in writing of the Grievance within 10 working days;
2. Conduct a complete investigation of the Grievance within 20 working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, the Covered Person shall be notified in writing on or before the 20th working day and the investigation shall be completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;
3. Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance and notify you in writing of the Plan's decision regarding the Grievance and of the right to file for a second-level review. The notice shall explain the resolution of the Grievance and the right to file for a second-level review in terms which are clear and specific;
4. Within 15 working days after the investigation is completed the Covered Person and/or the person who submitted the Grievance will be notified in writing of the Plan's decision regarding the Grievance. The notice of the Plan's decision will include the Covered Person's or the Plan's rights to file a request for review with the Missouri Department of Commerce & Insurance.
5. The Covered Person has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce & Insurance, then it shall be resolved by referral to an independent review organization.

Second Level Grievance

Second-level Grievance reviews must be submitted within 180 days from the date of written notice from the Plan to the person who submitted the First-level Grievance.

- Upon receipt of a request for second-level review, the Plan will submit the Grievance to a Grievance advisory panel consisting of:
  - Other Members and the Representatives of Cox HealthPlans who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance.
- Where the second level review involves an Adverse Determination, and the grievance advisory panel makes a preliminary decision that the determination should be upheld, the Plan shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

- In the event that both independent reviews concur with the grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both independent reviewers disagree with the grievance advisory panel's preliminary decision, the initial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion. Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable.
- The Covered Person has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce & Insurance, then it shall be resolved by referral to an independent review organization.

EXPEDITED REVIEW OF GRIEVANCES

The Plan has written procedures for the expedited review of a Grievance involving a situation where the time frame of the standard Grievance procedures would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, for purposes of the Grievance register requirements, the request shall not be considered a Grievance unless the request is submitted in writing. Expedited review procedures shall be available to a Covered Person, the representative of a Covered Person and to the Provider acting on behalf of a Covered Person. Please call the phone number on the back of your ID card to submit an oral request for an expedited review and for instruction on how to submit the request in writing.

The Plan will notify the Covered Person orally within 72 hours after receiving a request for an expedited review of the Plan's determination and shall provide written confirmation of its decision covering an expedited review within 3 working days of providing the notification of the determination.