YOUR APPEAL RIGHTS

THIS NOTICE DESCRIBES YOUR RIGHTS TO FILE AN APPEAL WITH COMMUNITY HEALTH GROUP. PLEASE REVIEW IT CAREFULLY.

A grievance is an expression of dissatisfaction that a member communicates to us. Grievances include complaints and appeals.

Filing a grievance can be as easy as calling Member Services. The representative who answers your call will assist you and try to resolve your problem immediately. If your problem is harder to solve, the representative will keep you up to date on the status as we work to resolve the issue.

You can also call Member Services and ask that we mail you a grievance form. Then, fill out the form and return it to us to file your grievance. Your primary care site also has grievance forms. Stop by and pick one up. The site also has someone who can help you fill out the form. In this case, please call to make sure the person is available to help you.

Grievances can also be filed 'online' through our internet web site, www.chgsd.com.

For us to accept your grievance for resolution, it must be filed with us within 180 days following any incident or action that is the subject of the member's dissatisfaction.

If it is needed, we can assist members who have a grievance, and who have limited English proficiency or a visual or other communicative impairment, with translations of grievance procedures, forms, and responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Let us know if you need assistance.

If you submit your grievance by telephone and we resolve it by the end of the next business day, we let you know, and you won't hear anything else from us on the matter. If your problem takes more time to resolve, we send you a letter within five days of receiving your grievance. The letter tells you that we are working on resolving it.

Our clinical staff is involved in reviewing all grievances that involve issues about the quality of care you received.

Please note: Many of our members are part of a medical group or IPA. These groups have the authority to make Prior Authorization decisions. If you are a member of such a group, you should know that our entire appeal process, as well as the IMR process, also applies to their decisions. If you have a complaint about or you wish to file an appeal involving a decision made by a medical group or IPA, you should file your grievance directly with Community Health Group.

To file a grievance, call Member Services at 1-800-224-7766, use our internet web site, www.chgsd.com, or write to us at:

Community Health Group

Grievance Coordinator

1-800-224-7766

740 Bay Boulevard

Chula Vista, CA 91910

Non-urgent vs. Urgent Grevances

If your grievance is non-urgent, you will hear back from us within 30 days of the date we receive your grievance. At that time, we tell you the final resolution and provide information about your other rights with respect to the grievance.

Urgent grievances are handled more quickly. An urgent grievance is one that involves an immediate and serious threat to your life or health. An urgent grievance includes, but is not limited to, severe pain or the potential for loss of life, limb or major bodily function. For urgent grievances, you will hear back from us within three days - or sooner if need be. This time may be extended by 14 days if the member requests an extension, or we show (to the DHS upon its request) that there is a need for additional information about the grievance and the delay is in the member's interest. When we receive a grievance that we determine to be urgent, we immediately tell you of your right to contact the California Department of Managed Health Care (DMHC). If you have an urgent grievance, there is no requirement that you participate in our grievance process before contacting the DMHC for assistance.

Some urgent grievances may also be eligible for review through the State's Expedited Fair Hearing process. For more information, please see the section below entitled "Expedited State Fair Hearing Process."

Both non-urgent and urgent grievances may be reviewed and decided upon by our Grievance Committee. You have the right to submit information for review by the Grievance Committee.

Please keep in mind that our clinical staff is involved in reviewing all grievances that involve quality of care issues.

When a Grievance Involves an Appeal

We may make decisions with which you are not satisfied. For example, you may be dissatisfied with our decision to deny, delay or modify a health care service, and ask us to reconsider our decision. Or, we have made a decision that adversely affects your relationship with us. In cases like these, you may file an appeal, which is a request to change a decision.

From the date we, or one of our contracted medical groups or IPAs, notify you of our decision to deny, delay or modify a health care service, you have 180 days to appeal. If circumstances beyond your control prevent you from filing an appeal within 180 days, you must file an appeal

as soon as reasonably possible. If you are unable to file an appeal within 180 days, you must explain to us why you were unable to meet this timeline, and show us that you filed the appeal as soon as was reasonably possible. When you appeal our decision, the same timelines for processing a grievance apply:

- We will reconsider our decision and get back to you within 30 days of receiving your appeal.
- If we determine the appeal to be urgent, we will get back to you within three calendar days or sooner if the medical condition requires it.

For a Member to have his or her provider submit an appeal to us, the provider must have the Member's written consent. Member benefits continue if the member files an appeal or a request for a State Fair Hearing (described below) within the timeframes specified for filing. A member may be required to pay the cost of services furnished while an appeal is pending, if the final decision is adverse to the member.

Your Other Options

Outside of our grievance process, you have several options. You can ask for help through any of three State government departments that take complaints from health plan members. The chart that follows shows how to contact these departments.

State of California		
Department of	**For Information About**	**How to Contact**
Social Services	Fair Hearing Process Public Inquiry and Response Unit	Call 1-800-952-5253
Health Services (Health Services Ombudsman)	Medi-Cal Managed Care Rights and Responsibilities, including but not limited to information about Expedited State Hearing	Call 1-888-452-8609
	Help Center, Independent Medical Review	California Relay Service: 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) Internet web site: http://www.hmohelp.ca.gov

Here is more information on how these State Departments can help you.

State Fair Hearing Process

The Department of Social Services administers a Fair Hearing process. You have a right to a State Fair Hearing if services that your doctor requested have been denied or stopped. If you get a written notice denying medical services, that notice will include a form for you to file a

grievance with Community Health Group. But it is your right to request a State Fair Hearing with or without:

- Filing a grievance with us
- Waiting for a decision from us about your grievance.

To be eligible for a State Fair Hearing, you must request it within 90 days of receiving our decision to deny or stop services. To request a hearing, call the Department of Social Services at 1-800-952-5253, or send a letter asking for the hearing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

If you send a letter to the Department of Social Services to request a hearing, include in it your name and social security number, the name of your health plan (Community Health Group) and the reason for your appeal. Ask for an interpreter if you need one at the hearing. Keep a copy of your letter. If you need assistance with asking for a State Fair Hearing, please call Member Services at 1-800-224-7766. If you are granted a State Fair Hearing, you may represent yourself or be represented by an authorized third party such as legal counsel, relative, friend or any other person.

Some grievances, due to their urgency, may be eligible for an Expedited State Hearing (ESH). Please see the following explanation of the ESH Process.

Expedited State Hearing Process

As part of the State Fair Hearing system, the State provides a process for Expedited (faster) State Hearings (ESH). As in the standard State Fair Hearing process, during an ESH, you may represent yourself or be represented by an authorized third party such as legal counsel, relative, friend or any other person.

A grievance that involves a denial of service may be eligible for an ESH if either of the following conditions is met:

- The member bypasses our internal grievance process and proceeds directly to a State Fair Hearing or if the member files for a State Fair Hearing at the same time as filing a grievance through our internal grievance process. In this case, ESH would be available if the member's condition is such that either we or the member's provider indicate that taking the time for a standard resolution of the grievance could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Or,

- The member files for a State Fair Hearing after filing an urgent grievance with

Community Health Group, and either:

a) We do not resolve the urgent grievance within 72 hours, but we indicate to the State that the grievance meets the criteria for expedited resolution, or,
b) We do resolve the urgent grievance in expedited fashion within 72 hours, but the decision is wholly or partially adverse to the member.

If you feel you need an ESH, let either your provider or us know. If your provider feels you need an ESH, please advise him or her to let us know also. That will help speed up the application.

A request for an ESH may be made orally or in writing. However, before the State will schedule an ESH, either we or your provider must give to the State, in writing:

- A statement that the member's condition satisfies the criteria for expedited resolution.
- Specific information describing the grievance.

Requests for ESHs are sent to:

Expedited Hearing Unit
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
FAX: (916) 229-4267

General information about the ESH process is available from the DHS, Medi-Cal Managed Care Division, Office of the Ombudsman at 1 (888) 452-8609.

Department of Health Services

You can call the DHS Ombudsman for help with some complaints. The Ombudsman program can also give you information about health plans, help you get needed forms, and find out if you are still Medi-Cal eligible according to the State's records.

It is your right to call this office with or without:

- Filing a grievance with us.
- Waiting for a decision from us.

Department of Managed Health Care

The DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-224-7766** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been

satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review

If medical care that is requested for you is denied, delayed or modified by Community Health Group or a plan provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the DMHC, information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, Community Health Group will provide coverage for the health care services.

An IMR is available in the following situations:

1. (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have received urgent care or emergency services that a provider determined was medically necessary, or

   (c) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review; and

2. the disputed health care service has been denied, modified, or delayed by Community Health Group or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. you have filed a grievance with Community Health Group and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

   If your grievance qualifies for expedited review, you are not required to file a grievance with Community Health Group prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow Community Health Group's grievance process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization designated by DMHC will provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; the IMR organization will provide its determination within three (3) business days. At the request of the experts, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call Community Health Group's Member Services at 1-800-224-7766 The hearing impaired may contact Member Services through the California Relay Service at (1-800-735-2929).

Independent Medical Review (IMR) for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in Community Health Group's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

To be eligible for an IMR, you must request the IMR within 180 days (six months) of the date you were notified of a decision to deny, delay or modify authorization or payment for a health care service. If you do not request the IMR within that time, it cannot be reviewed by the IRO, unless the Department of Managed Health Care requires otherwise.
The IMR process is in addition to any other procedures or processes that may be available to you. If you decide not to participate in the IMR process, you may be giving up any statutory right you have to take legal action against our health plan. If you need more information, please call or write the Member Services Department.

We designed our grievance process to treat our members fairly. Sometimes, you or your doctor may not agree with our decisions. We fully support your right to call the State. We only ask that you let us try to help first. Remember that we solve most problems during the first phone call!

For help with any problem with your health plan or provider, call

Member Services at:

1-800-224-7766

24 hours per day, 7 days per week

Or, write to us at:

Community Health Group

Attn: Grievance Coordinator

740 Bay Boulevard

Chula Vista, CA 91910