QUALIFIED HEALTH PLANS

Grievance Procedures

Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

Filing a Grievance.

You can contact Us by phone at the number on Your ID card in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.metroplus.org. You can opt out of electronic notifications at any time.

Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

- Expedited/Urgent Grievances:
    - By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

- Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)
    - In writing, within 15 calendar days of receipt of Your Grievance.
- Post-Service Grievances: (A Claim for a service or treatment that has already been provided.)
    - In writing, within 30 calendar days of receipt of Your Grievance.
- All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)
    - In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

Assistance.

If You remain dissatisfied with Our Grievance determination, or at any other time You are dissatisfied, You may:

- **Call the New York State Department of Health at 1-800-206-8125 or write them at:**
    - New York State Department of Health
    - Office of Health Insurance Programs
    - Bureau of Consumer Services – Complaint Unit
    - Corning Tower – OCP Room 1609
    - Albany, NY 12237
    - E-mail: managedcarecomplaint@health.ny.gov
    - Website: www.health.ny.gov
- If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:
    - Community Health Advocates
    - 633 Third Avenue, 10th Floor
    - New York, NY 10017
    - Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
    - Website: www.communityhealthadvocates.org