HealthPlus Member Satisfaction Plan Summary	Grievance Procedures

(May be provided to members upon request)

HealthPlus Member:

Because your satisfaction is one of the main goals at HealthPlus, we have established a Member Satisfaction Plan. The Member Satisfaction Plan has two main purposes. The first purpose is to see that you receive the answers to questions you have about HealthPlus. The second is to provide ways of reaching fair solutions to any problems you may have with HealthPlus.

When you have a question or problem, please call the Customer Service Department at:

1-800-332-9161

Customer Service staff will document and date the source of all member contacts. Most inquiries can be resolved within two working days.

If you are not happy with any aspect of HealthPlus' operations or benefits, and you cannot resolve your concerns with the Customer Service Department, you or a person you have authorized to represent you, can use the Member Satisfaction Plan. You must file your grievance within two (2) years of the event giving rise to the grievance or within two (2) years of discovering the facts giving rise to the grievance. For HealthPlus Partner Medicaid and HealthPus MedicarePlus members, a grievance must be filed within ninety days following the date of receipt of the notice of Adverse Determination.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your grievance. You may submit written comments, documents, records and other information relating to the grievance.

Routine Grievance

The Member Satisfaction Plan has two (2) internal steps for routine grievances: Grievance and Grievance Appeal. We have thirty (30) calendar days to complete these two steps, but we can extend the time by any amount of time that you allow us to.

Step One: Grievance

Whenever your concerns regarding HealthPlus cannot be handled by the Customer Service Department, you can file a grievance in the following ways:

- Call:
  1-800-332-9161

- Mail:
  2050 S. Linden Rd
  PO Box 1700
  Flint, MI 48501-1700

- Fax:

(810) 733-1947

- Request a personal meeting

HealthPlus will respond in writing to your grievance within fifteen (15) calendar days of receiving it. At that time, you will be informed of HealthPlus' investigation into your grievance, any action taken and advised of your rights to further review if your grievance has not been resolved in your favor.

Step Two: Grievance Appeal

If you are not satisfied with the outcome of your grievance, you can appeal it within a reasonable amount of time following notification of the decision. HealthPlus will schedule a meeting of the Grievance Appeal Committee within thirteen (13) calendar days of receipt of your request to file a Grievance Appeal.

You have the opportunity to appear and speak before the Grievance Appeal Committee with or without representation. If you cannot appear in person, you also have the option of speaking by telephone or other appropriate technology.

You will receive notification of the Grievance Appeal Committee's decision within two (2) calendar days of the meeting. This will be HealthPlus' final decision on your grievance. You will be advised of your right to further appeal to the State of Michigan, Office of Financial and Insurance Regulation.

External Review

If you have exhausted your rights under the HealthPlus Member Satisfaction Plan, or if you have not received a response from us at the end of fifteen (15) calendar days from filing your appeal under Step Two: Grievance Appeal, you can appeal to the Office of Financial and Insurance Regulation at no cost to you by writing or calling:

State of Michigan
Office of Financial and Insurance Regulation Appeals Section
611 W. Ottawa Street
P.O. Box 30220
Lansing, Michigan 48909-7720

You may also call:

(517) 373-0220 or

1-977-999-6442 (toll-free)

By submitting a request for external review, you are authorizing HealthPlus and your health care providers to disclose your health information, including medical records that are relevant to the review process.

If the final decision of HealthPlus was an adverse determination, you must file your request for external review with the Office of Financial and Insurance Regulation within sixty (60) calendar days following receipt of HealthPlus' final decision.

An "adverse determination" is a determination that an admission, availability of care, continued stay or other health care service has been reviewed and denied, reduced or terminated. You need to complete a Request for External Review form for the Office of

Financial and Insurance Regulation to be able to process your request. You can obtain the form from HealthPlus' Customer Service Department.

If your request for external review of an adverse determination is found to be appropriate for external review, the Commissioner of the Office of Financial and Insurance Regulation will either review the case or assign an Independent Review Organization, made up of independent clinical reviewers, to review your case. Both HealthPlus and you will have an opportunity to provide this Independent Review Organization with supporting documentation. Within fourteen (14) calendar days, the Independent Review Organization will recommend to the Commissioner to uphold or reverse HealthPlus' determination. The Commissioner has seven (7) working days to make a decision.

If your request for external review does not involve an adverse determination, but is found to be appropriate for external review, the Commissioner will assign his or her staff to review your case. Within fourteen (14) calendar days, the Commissioner will make a decision.

If you would like more information about your right to an external review, you may contact the Office of Financial and Insurance Regulation at the address or telephone numbers listed above.

Expedited Grievance

If you (or another person, including a physician, who is authorized in writing to act on your behalf) believes that due to your medical status, resolution of your grievance within HealthPlus' normal time frames would seriously jeopardize your life or health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately, the expedited grievance process may be utilized. You may only request an expedited grievance when we have denied your request for benefits prior to your having received a service.

HealthPlus will determine whether an expedited grievance is warranted based on the particular facts and circumstances of each request. In making such a determination, HealthPlus will supply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If an expedited grievance is not warranted, the routine grievance process will be followed. HealthPlus will make a determination concerning your expedited grievance and communicate that to you and your physician as expeditiously as the medical condition requested, but no later than seventy-two (72) hours after receipt. You and your physician will be provided with written confirmation of this determination within two (2) working days or three (3) calendar days, whichever is less, following the oral determination.

External Review

A request for an expedited external review may be forwarded to the Office of Financial and Insurance Regulation at no cost to you within ten (10) calendar days following receipt of HealthPlus' determination. You may write or call them at the following address and telephone numbers:

Office of Financial and Insurance Regulation Appeals Section,
611 W. Ottawa Street
P.O. Box 30220
Lansing, Michigan, 48909-7720

You may also call:

(517) 373-0220 or

1-877-999-6442 (toll-free)

By submitting a request for external review, you are authorizing HealthPlus and your health care providers to disclose your health information, including medical records, which are relevant to the review process. You need to complete a Request for External Review form for the Office of Financial and Insurance Regulation to be able to process your request. You can obtain the form from the HealthPlus Customer Service Department.

If a physician believes that due to your medical condition, resolution of your expedited grievance within HealthPlus' time frames for an expedited grievance would seriously jeopardize your life or health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately, and you have filed a request for an expedited grievance with HealthPlus, you may request an expedited external review from the Office of Financial and Insurance Regulation.

Upon receipt of your request, the Commissioner will immediately decide if it is appropriate for external review and, if so, assign it to an Independent Review Organization. If the Independent Review Organization decides that you do not have to first complete the HealthPlus expedited grievance process, it will review your case and make a recommendation to the Commissioner within thirty-six (36) hours to uphold or reverse HealthPlus' determination. The Commissioner has twenty-four (24) hours to make a decision.

If you would like more information about your right to an external review, you may contact the Office of Financial and Insurance Regulation at the address or telephone numbers listed in this section.