Blue Shield of California member grievance procedure

If you disagree with Blue Shield of California's (Blue Shield) determination, you (or your provider or a representative on your behalf) may file a grievance by 1) calling the Customer Service/Member Services Department toll-free number, 2) writing to the Customer Service/Member Services Department, or 3) by submitting a completed Grievance Form. A Grievance Form can be obtained either by contacting Customer Service/Member Services or by logging in to **blueshieldca.com**. The completed Grievance Form should be submitted either online or to the address below. Grievances are resolved within 30 days. The grievance system allows you to file grievances for at least 180 days following an incident or action that is subject to your dissatisfaction. Please indicate that you are filing a grievance, and include any documents or information that you believe may be relevant to the review of your grievance.

- HMO members call **(800) 424-6521**
- PPO members call **(800) 351-2465**
- CALPERS members call **(800) 334-5847**
- Hearing- and speech-impaired call **(888) 852-5345** or TTY **(800) 241-1823**
- Online: **blueshieldca.com**
- Write: Blue Shield of California
  Attn: Customer Service Grievances
  P.O. Box 5588
  El Dorado Hills, CA 95762-0011

Expedited decisions

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function. Blue Shield will evaluate your request and medical condition to determine if it qualifies for an expedited decision, which will be processed as soon as possible to accommodate the patient's condition, not to exceed 72 hours. To request an expedited decision, you or your physician on your behalf can call or write to Member Services as listed above. Specifically state that you want an expedited decision, and that waiting for the standard process might seriously jeopardize your health.

The Department of Managed Health Care notification

The California Department of Managed Health Care (DMHC) is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 424-6521** (HMO members), **(800) 351-2465** (PPO members), or **(800) 334-5847** (CalPERS members) and use your health plan's grievance process before contacting the DMHC. 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 DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 DMHC also has a toll-free telephone number **(888) HMO-2219**, and a TTY line, **(877) 688-9891**, for the hearing- and speech- impaired. The DMHC's website **www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

Independent Medical Review through the DMHC – voluntary appeal procedure

Members have the right to request an IMR through the DMHC, as indicated in the above paragraph. Members may apply for an IMR if A) the member's provider has recommended a healthcare service as medically necessary, or B) the member has received urgent care or emergency services that a provider determined was medically necessary, or C) in the absence of a provider recommendation or the receipt of urgent care or emergency services, the member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review. Members can contact the DMHC directly.

Employee Retirement Income Security Act (ERISA) notification

If your employer's health plan is governed by the Employee Retirement Income Security Act (ERISA), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.

You are entitled to, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Right to request review of rescission, cancellation, or nonrenewal of your enrollment or subscription

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

1. First, file your complaint with Blue Shield:
   - You can file a complaint with Blue Shield by calling the number listed on page 1 or by visiting **blueshieldca.com**.
   - You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled, or not renewed.
   - If your problem is urgent, an expedited decision will be made as outlined above.
   - If your problem is not urgent, a decision will be made within 30 days as outlined above.
2. Taking your complaint to the California Department of Managed Health Care (DMHC):

   If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you can file a complaint with the DMHC if:
   - You are not satisfied with Blue Shield's decision about your complaint; or
   - You have not received a decision within 30 days (or within 3 days if the problem is urgent).
   - The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

   An optional DMHC complaint form is available at www.healthhelp.ca.gov.

   Or contact: Help Center, DMHC, 980 Ninth St, Suite 500, Sacramento, CA 95814-2725 or by fax at (916) 255-5241

   Or call: (888) 466-2219, TTY (877) 688-9891

   There is no charge to call. Help is available in many languages.
3. Continuation of coverage:

   If you receive notice that your coverage is being rescinded, canceled, or not renewed for any reason besides failure to pay premiums, **and** if your coverage is still in effect when you submit your complaint to the DMHC, Blue Shield must continue your coverage during, until the review process is completed. If your coverage is continued, **you must still pay your usual dues/premium**.

   If your coverage has already ended when you submit your request for review, Blue Shield is not required to continue your coverage. However, you can still request a review of Blue Shield's decision to rescind, cancel, or not renew your coverage by following the complaint process described above. If you submit a complaint to the DMHC and the Director decides in your favor, Blue Shield must reinstate your coverage, back to the date of the rescission, cancellation, or nonrenewal.

An Independent Member of the Blue Shield Association C15653 (12/11) 7188