Landmark's Member Grievance Resolution

If you have a problem concerning your eligibility, coverage, denial of benefits, quality of care or any other matter relating to your chiropractic and acupuncture benefit plan, you are encouraged to call Landmark's Customer Service Department at (800) 298-4875. One of our Customer Service Representatives will make every effort to respond to your questions and address your concerns. If you are not satisfied with efforts to solve a problem, you may submit a formal grievance or quality of care complaint in person, by telephone, or in writing to Landmark. You have at least 180 calendar days to submit your grievance following any incident or action that is the subject of your dissatisfaction.

Landmark Healthplan of California, Inc.
ATTN: Quality Management Department
1610 Arden Way, Suite 280
Sacramento, California 95815
(800) 298-4875

(888) 565-4236 (relay service for the hearing-impaired)
www.LHP-CA.com

Please include your name, address, telephone number, social security number and details of the problem. If you wish assistance in filing a complaint or would like a copy of Landmark's Grievance Form, our Customer Service Representatives and Quality Management Coordinators are available to help you. Large-print grievance materials and forms are available upon request for the visually impaired. In addition, if you prefer use of a language other than English, we can provide translated grievance materials and forms, and we have multilingual staff available and access to Language Line Services interpreters to assist you through the filing process. Also, you may enter your grievance directly into an online form available at the web site given above, where you can preview and edit grievances before they are submitted. The information is transmitted directly to the Plan via the Plan's secure server.

We will then:

- Confirm in writing within five (5) calendar days that we received your complaint;
- Review your complaint and inform you of our decision in writing within thirty (30) days;
- Or, if your case involves an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function, we will expedite the process as an urgent grievance within three (3) days from receipt of your request.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE (DMHC):

After completing Landmark's grievance process or participating in the process for at least thirty (30) days, you or your designee may submit the grievance to the DMHC for review. If the DMHC determines your case involves an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function as determined by the DMHC, or in any other case where the DMHC determines that an earlier review is warranted, you shall not be required to complete Landmark's initial grievance process or participate in the process for at least thirty (30) days before submitting a grievance to the DMHC. In reviewing the information submitted by you or your designee, the DMHC may ask for additional information and may hold an informal meeting with the involved parties. The DMHC shall send a written notice to you or your designee of the final disposition of the grievance and reason for decision within thirty (30) calendar days of receipt of the request for review unless the Director determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance.

The California Department of Managed Health Care 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 **(800) 298-4875** 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.

VOLUNTARY MEDIATION OR BINDING ARBITRATION

If you are dissatisfied with the resolution of your grievance, either before or after submitting your grievance to the DMHC, you may submit or request that Landmark submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).

(i) Voluntary Mediation – In order to initiate mediation, you, or an agent acting on your behalf, may submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

(ii) Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims relating to the delivery of services under the Plan and claims of professional malpractice (that is, as to whether any professional services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), between you (including any heirs or assigns) and Landmark, except for claims arising under Section 502(a) of ERISA shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. You and Landmark are both giving up your constitutional right to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service to which the parties may agree in writing. The parties will mutually endeavor to agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.
Arbitration hearings shall be held in Sacramento County, California, or at such other location as the parties may agree to in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, Landmark may assume all or part of your share of the fees and expenses of JAMS and the arbitrator, provided you submit a hardship application to JAMS. This application will be provided by JAMS upon your request to Landmark. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking monetary damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

BY ENROLLING IN LANDMARK BOTH MEMBER (INCLUDING ANY HEIRS OR ASSIGNS) AND LANDMARK AGREE TO WAIVE THE CONSTITUTIONAL RIGHT TO A JURY TRIAL

AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS EVIDENCE OF COVERAGE.

INDEPENDENT MEDICAL REVIEW PROCESS FOR DISPUTED HEALTH CARE:

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by Landmark or by one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified or delayed by Landmark or one of its contracting providers, in whole or in part because the service was not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Landmark must provide you with an IMR application form with any grievance disposition letter that denies, modifies or delays health care services. A decision to not participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Landmark regarding the disputed health care service.

Eligibility

Your application for IMR will be reviewed by the DMHC to confirm that:

1) A) Your provider has recommended a 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.

2) The disputed service has been denied, modified, or delayed by Landmark based in whole or in part on a decision that the service is not Medically Necessary.

3) You have filed a grievance with Landmark or its contracting provider, and the disputed decision is upheld, or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow Landmark's grievance process in extraordinary or compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines that the service is Medically Necessary, Landmark will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or the immediate serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

INDEPENDENT MEDICAL REVIEW PROCESS FOR EXPERIMENTAL AND INVESTIGATIONAL TREATMENT:

You may also request an IMR to re-examine a Landmark coverage decision based upon your request for experi-mental or investigational treatment. You do not need to file a grievance with Landmark prior to submitting a request for IMR review of your experimental and investigational treatment request. The IMR process for reviewing decisions regarding the denial, modification or delay of requested experimental and investigational treatment is similar to the IMR process previously described for disputed health care services, with the following exceptions:

Eligibility

In order for Landmark's coverage decision to be reviewed by the IMR process, you must meet all of the following criteria:

1) You must have a life-threatening or seriously debilitating condition.
   A) "Life-threatening" means either or both of the following:

i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
ii) Diseases or conditions with potentially fatal outcome, where the end-point of clinical intervention is survival.

B) "Seriously debilitating" means diseases or condition that cause major irreversible morbidity.

2) Your practitioner must have certified your life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the condition, for which standard therapies would not be Medically Necessary or for which there is no more beneficial standard therapy covered by Landmark than the therapy proposed as specified in paragraph 3 below.

3) Either a) your Participating Practitioner has recommended a drug, device, procedure or other therapy that the Participating Practitioner certifies in writing is likely to be of more benefit to you than any available standard therapy, or b) you or your practitioner has requested a therapy that, based on two documents of medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4) Coverage for this drug, device, procedure or other therapy recommended or requested as outlined in paragraph 3 above has been denied by Landmark.

5) The specific drug, device, procedure or other therapy recommended or requested would be a Covered Service, except that it has been denied as experimental or investigational.

If you meet the criteria listed above, Landmark shall offer you the opportunity to have the requested therapy reviewed under the Independent Medical Review process and will notify you of such opportunity within five (5) business days of Landmark's decision to deny coverage. Included with this notice is an application and an addressed envelope that you may return to the DMHC to initiate the IMR process. This review is free of charge to you.

The analyses and recommendations of the experts on the IMR panel shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for you than any available standard therapy, and the reasons the experts recommend that the therapy should or should not be provided by Landmark. This written response will be provided in writing to you, your Participating Practitioner and Landmark within thirty (30) days of the receipt of your request for review. If your Participating Practitioner determines that the proposed therapy would be significantly less effective if not promptly initiated, the analysis and recommendations of the experts shall be rendered within seven (7) days of the request. The IMR panel experts may extend the deadline by up to three (3) days for any delay in providing the documents necessary for review. For urgent cases involving imminent and serious threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or the immediate serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For information about the IMR process, to request an application, or for assistance in completing the application, please call Landmark's Customer Service Department at (800) 298-4875.