GRIEVANCE PROCEDURE

Retirees participating in the Cigna Medicare Plans F or N and the Cigna Medicare Part D Pharmacy Plan should refer to Article 6.04 for Medicare Appeals process as Medicare is the primary carrier.

All others should refer to the following Grievance Procedure.

This Grievance Procedure follows a confidential method of hearing and resolving grievances involving interpretations of the Plan. A Grievance is a formal complaint filed by a Covered Person, or an authorized representative of a Covered Person, regarding eligibility, rescission of coverage, post service claim denials, pre-service requests for benefits, covered health services/benefits, or service issues.

This Internal Grievance Procedure is comprised of four steps with the exception of an Expedited Grievance and the External Grievance Procedure, which are outlined later in this procedure. The Grievance Procedure is only available to a Covered person who initiates Step One of the Grievance process no later than six (6) months from the date on which a claim or service is initially denied. During or before any of these steps, particular individuals or entities may need access to Protected Health Information (PHI) about the Covered Person to resolve the problem or complaint. Therefore, the Covered Person or an authorized representative may be required to sign a written authorization allowing such information to be used and/or disclosed prior to or during, any of the four steps of the grievance procedure. All of the procedures in the following four steps are subject to all applicable federal, state, and local laws and regulations.

(a) Step One:

Many complaints and issues can be resolved directly with the individual or organization through personal and informal discussion about the issue. The Covered Person, or an authorized representative, should first make a good faith effort to resolve the issue directly with the individual or organization with whom the issue exists. The appropriate individual or organization will make every attempt to resolve the issue and will respond in writing to the Covered Person, or an authorized representative, within sixty (60) days from the date the initial complaint was registered. Generally, the appropriate contacts for this purpose are as follows:

PROBLEM WITH….	**CONTACT….**
Cigna (All medical plans) • Post service claim denials • Participating providers issues • Pre-certification issues • Mental health issues • Substance abuse issues	Cigna Health Plans P.O. Box 182223 Chattanooga, TN 37422-7223 1.800.244.6224

PROBLEM WITH….	CONTACT….
CVS/Caremark • Pharmacy Issues • Benefit issues • Formulary Issues • Clinical Prior Authorizations • Step Therapy Programs	CVS/Caremark One CVS Drive Woonsocket, RI 27895 1.800-378-9264
Other • Eligibility • Effective dates • Benefit issues • General information	OCPS Risk Management Office 445 W. Amelia Street Orlando, FL 32801 407.317.3245

If the Covered Person, or authorized representative, needs guidance as to which organization to contact, he/she should call the OCPS Insurance Benefits Department and speak to either the Senior Director, Risk Management or the Assistant Director, Risk Management.

(b) Step Two:

To initiate Step Two of the Grievance Procedure, the Covered Person or an authorized representative should submit the Step Two Grievance in writing no later than sixty (60) days following the decision rendered under Step One. If the Covered Person or an authorized representative fails to submit the Grievance within that sixty (60) day time period, the Covered Person will be deemed to agree with the Step One findings and resolution, and will forfeit any rights he or she has to proceed with Step Two of the Grievance Procedure. Anyone needing assistance with filing a Step Two Grievance may contact the OCPS Risk Management Department. The written Grievance should contain the following information and may be submitted to either one of the addresses noted below.

<u>Needed Information</u>

- The Covered person's name, address and identification number
- A summary of the Grievance along with any additional supporting documentation /medical records, and a description of the relief sought
- The Covered Person's signature
- The date the Grievance is signed
- The written Grievance should be submitted to:

Addresses (submit to one)

Gallagher Benefits Services, Inc.
200 South Orange Avenue, Suite 750
Orlando, FL 32801
Phone: 407.563.3576
Facsimile: 407.370.3057 Or

Orange County Public Schools Risk
Management Department
Attention: Senior Director, Risk Management 445 W.
Amelia Street
Orlando, FL, 32801
Phone: 407.317.3245
Facsimile: 407.317.3359

Gallagher Benefit Services shall commence an investigation in an effort to resolve the issue, and will respond in writing to the Covered Person, or an authorized representative, within sixty (60) days of receipt of the Grievance.

If Step Two of the Grievance does not provide a satisfactory result, the Covered Person or an authorized representative may initiate Step Three of the Grievance Procedure.

(c) Step Three:

To initiate Step Three of the Grievance Procedure, the Covered Person or an authorized representative may request a hearing of the Grievance Committee by completing the Grievance Hearing Request Form that was provided with the written decision under Step Two of the Grievance Procedure. The Grievance Hearing Request Form must be submitted no later than sixty (60) days following the date of the written decision under Step Two. If the Covered Person or an authorized representative fails to request a Grievance Hearing within that sixty (60) day time period, the Covered Person or an authorized representative will be deemed to agree with the Step Two decision, and forfeit any rights he or she has to proceed to Step Three of this Grievance Procedure.

The Grievance Hearing Request Form, along with any additional information the Covered Person or an authorized representative deems relevant, should be submitted to Gallagher Benefit Services at the following address:

Gallagher Benefits Services, Inc.
200 South Orange Avenue, Suite 750
Orlando, FL 32801
Phone: 407.563.3576
Facsimile: 407.370.3057

(i) The Grievance Committee shall consist of: (A) one (1) Chairperson, to be filled by the OCPS certified healthcare lawyer; (B) one (1) representative from Gallagher Benefit Services; (C) two (2) representatives of the OCPS Risk Management Department; and (D) any two (2) representatives of the following healthcare vendors as determined by the Covered Person's issue: the Contracted Medical Services vendor, the Contracted Behavioral Health Services vendor or the Pharmacy Benefit vendor. The Chairperson will chair the Grievance Committee, run the Grievance Hearing, ensure minutes are recorded and ensure that a written determination of the Grievance Committee's decision is sent to the Covered Person or an authorized representative in accordance with Step Three of the Grievance Procedure. The Covered Person or authorized representative will have twenty (20) minutes to present his or her case and provide any additional information they would like considered.

A member of the Grievance Committee may participate by telephone or teleconference at any Grievance Committee meeting if such member, due to hardship or unanticipated inconvenience, cannot attend such meetings in person. Any member of the Grievance Committee participating by telephone or teleconference must, however, affirm on the record that he/she understands the nature of the problem presented by the Covered Person or authorized representative prior to considering the Covered Person's position.

The Grievance Committee will meet to resolve the issue within sixty (60) days of receiving the Grievance Committee Request Form. Written notification of the Committee's decision will be sent by the Chairperson within thirty (30) days of the meeting. The Grievance Committee shall make one of the following decisions:

(ii) Affirm the previous decision of the issue; or

(iii) Rule the issue warrants a different response and make appropriate recommendations to the Risk Management Department, the Contracted Behavioral Health Services vendor, Cigna Healthcare, the Pharmacy Benefit Management vendor, or the provider involved; or

(iv) Any other action the Grievance Committee deems appropriate.

If Step Three of the Grievance Procedure does not provide a satisfactory result, the Covered Person or an authorized representative may initiate Step Four of the Grievance Procedure.

(d) Step Four:

To initiate Step Four of the Grievance Procedure, the Covered Person or an authorized representative, may request an Administrative Review by the Trustees of the OCPS Employee Benefits Trust ("the Trustees") by completing the Administrative Review Request Form that was provided with the written decision by the Grievance Committee.

The Administrative Review Request Form must be submitted no later than sixty (60) days following the date of the written decision under Step Three. If the Covered person or an authorized representative fails to request an Administrative Review within that sixty (60) day time period, the Covered Person will be deemed to agree with the Grievance Committee's decision and will forfeit any rights he or she has to proceed to Step Four of this Grievance Procedure.

The Administrative Review Request Form, along with any additional information the Covered Person or an authorized representative deems relevant, should be submitted to Gallagher Benefit Services at the following address:

Gallagher Benefits Services, Inc.
200 South Orange Avenue, Suite 750
Orlando, FL 32801
Phone: 407.563.3576
Facsimile: 407.370.3057

The Administrative Review will be scheduled immediately following the next regularly scheduled Trustees Meeting. The Trustees may request additional information and /or clarification for any party who has information regarding the Covered Person's issue. The Gallagher Benefit Services representative, the OCPS certified health care lawyer and the Senior Director, Risk Management will attend this meeting. The Gallagher Benefit Services representative will record the minutes of the meeting. The OCPS certified health care lawyer will provide a summary of the case noting the issue being grieved and the decision of the Grievance Committee with regard to the applicable plan rules that apply to the case under consideration. After review of the information compiled, the Trustees shall either support the decision of the Grievance Committee, or direct the Plan Administrator to take such action as is necessary to resolve the dispute. The Trustees shall be the final authority with regard to any OCPS Employee Benefits Trust disputes for internal appeals. The decision of the Trustees will be communicated to the Covered Person or the authorized representative within thirty (30) days following the Administrative Review. If this step of the Grievance Procedure does not provide a satisfactory result, the covered person or authorized representative may initiate an external review, described in section 3.02 (g) below.

(e) Expedited Grievance

An Expedited Grievance is only available to a Covered Person for a service(s) that has not been provided or approved and if not given, may cause the member to experience an adverse medical consequence(s) as a result in the delay of the requested service(s). An Expedited Grievance may be granted in any one of the following situations:

(i) In the opinion of the treating physician, the timeframe outlined in the Grievance Procedure would seriously jeopardize the member's life, health or ability to regain maximum function.

(ii) In the opinion of the treating physician, the timeframe outlined in the Grievance Procedure would cause the member severe pain which cannot be managed or reduced without the requested service(s).

(iii) The grievance involves an unauthorized inpatient admission.

(iv) The grievance involves the denial of ongoing inpatient hospitalization.

The request for an Expedited Grievance can be made to the Senior Director, Risk Management or Gallagher Benefit Services, Inc., Account Manager for Orange County Public Schools. While a written grievance with supporting data is preferred, a verbal request for an expedited grievance will be acceptable with one requirement; the Covered Person or an authorized representative or a guardian of a minor must sign a written authorization allowing the release of Protected Health Information (PHI). In addition, the following information must be provided:

(i) The Covered Person's name, address and identification number

(ii) A summary of the grievance, along with any supporting data: i.e. medical records, description of the relief sought, additional supporting clinical findings, etc.

(iii) An executed Release of Information form

(iv) Date of the submission of the grievance

The Gallagher Benefit Services Inc. Account Manager or the Senior Director, Risk Management will inform the OCPS certified healthcare lawyer or his/her designee, who will be the Chairperson of the Review Committee, of the need to hold an expedited review. Secondly the Account Manager or the Senior Director, Risk Management will schedule the review as soon as possible and cannot exceed three working days from receipt of the request. The Committee members will include the following people:

(i) Gallagher Benefit Services Inc. Account Manager or designee

(ii) Senior Director, Risk Management, Orange County Public Schools (OCPS) or designee

(iii) If medical or mental health issue is involved: Medical Director of the Covered Person's health plan or designee

(iv) Account Manager of the Covered Person's health plan or designee

(v) OCPS certified healthcare lawyer or designee (Chairperson)

(vi) If a pharmacy issue is involved: Pharmacy Doctorate from the Pharmacy Benefits Management provider

This Review Committee can meet in person or telephonically or a combination of both, though all members must be present at the same time. The Chairperson will record the proceedings of the Review Committee. The review of the Expedited Grievance must be completed within three (3) working days of receipt of the grievance request. The Chairperson of the Expedited Review Committee will provide the Covered Person or an authorized representative with a verbal response immediately after the Review Committee has reached a decision. A written response is to follow in no more than twenty-four (24) hours following the verbal communication of the Committee's decision to the Covered Person or an authorized representative.

(f) General Provisions:

(i) When a medical determination concerning the treatment of a Covered Person is disputed by a Covered Person or an authorized representative, representatives of the health plan may request a medical evaluation from a panel of physicians. This medical review may be obtained at any step of the grievance procedure. In cases involving a life-threatening illness, however, the grievance process shall be the same as the process set forth in the CTA and OESPA contracts if, and only if the grievance concerns the denial of a recommended experimental or investigative treatment or procedure not covered in the Plan Document. For purposes of this section, "life threatening illness" means an illness or condition which, if left untreated, will likely result in imminent death. For all other grievances, the following process will be utilized for a medical review:

A) Utilization Management will review the problem initially and refer the case to the Medical Director for review.

B) The Medical Director will submit the medical problem to a specialist for peer review of the case. Recommendations are requested in writing from the specialist.

C) The case is then submitted to a panel of physicians (UM Committee) for further review.

D) Upon completion of the review process, the Medical Director will review the recommendation with the Benefits Trust Administrator (Senior Director, Risk Management, OCPS). Medical recommendations must comply with the Plan.

(ii) Medical reviews will be reduced to writing and a copy will be forwarded to the Covered Person or an authorized representative with the disposition of the grievance.

(iii) If the dispute involves a mental health problem/complaint and is appealed to the Grievance Committee, an independent psychiatrist is added as a member of the Grievance Committee. The independent psychiatrist is appointed to the Grievance Committee after consultation with and approval of the Contracted Behavioral Health Services vendor. The Contracted Behavioral Health Services vendor agrees to accept and follow the appointed independent psychiatrist's medical judgment in all cases in which the Contracted Behavioral Health Services vendor initially denied payment or service within the scope of benefits.

(iv) The Covered Person or an authorized representative is entitled to personally appear before the Grievance Committee and has the right to be represented at the meeting.

(v) Representatives of the OCPS Employee Benefit Trust, through each step of this Grievance Procedure, have no authority to grant any request that is contrary to the Plan.

(vi) The Trustees of the OCPS Employee Benefit Trust shall have final authority regarding any OCPS Employee Benefit Trust disputes and have complete authority to revise this Grievance Procedure.

(g) External review process:

An External Review is only available to a Covered Person when a claimant has exhausted the internal appeals process. Appeals related to eligibility, contractual or legal interpretation without any use of medical judgment are not subject to external review under any Plan.

The written External Review request should contain the following information and should be submitted to the address below.

Needed Information

- The Covered person's name, address and identification number
- Written request for an External Review
- The Covered Person's signature
- The date the request is signed

Address (for submission)

Gallagher Benefits Services, Inc.
200 South Orange Avenue, Suite 750
Orlando, FL 32801
Phone: 407.563.3576
Facsimile: 407.370.3057

The request must be filed no later than four (4) months from the date the claimant received final notice of the adverse benefit determination.

(i) Preliminary review and referral to an Independent Review Organization (IRO):

The Plan has five business days from the receipt of the request to complete a preliminary review. The purpose of the preliminary review is to confirm that:

A) The Claimant was covered when the medical care was received;
B) The adverse benefit determination is not related to the claimant's eligibility for coverage;
C) The claimant has exhausted the internal appeals process; and
D) All of the information and forms required to process an External Review have been provided.

The claimant will be notified in writing no later than one (1) business day from the date the preliminary review is completed. If the claim is not eligible for External Review, the notice will include the reasons and information on how to contact the Department of Labor. If the claim is eligible for External Review, but the information or materials provided are incomplete, the notice will describe the information or materials needed to complete the request. The claimant will have 48 business hours from the date of receipt of the notice or until the end of the four (4) month filing time limit, whichever is later, to provide the missing information or materials.

(ii) Once it has been determined that the claim is eligible for external review, the claim will be assigned to an IRO no later than five (5) business days from the date the claim has been assigned to an IRO. The Plan will provide the IRO with any documents and information it considered in making the adverse benefit determination. The Plan's failure to provide this information when required does not extend the time frame for the process. In addition, if the Plan does not provide information and documents as required, the IRO is permitted to terminate the External Review and make a decision to reverse the Plan's decision. If the IRO terminates the Review, it must notify the claimant and the Plan within one (1) business day.

If the claimant sends any information directly to the IRO, the IRO must forward a copy of that information to the Plan within one (1) business day. The Plan then has an opportunity to reconsider its decision based on the new information.

Similar to the receipt of information from the Plan, this additional step does not extend or delay the review process.

If the Plan decides to reverse its previous decision and pay the claim based on the new information, it must notify the IRO and the claimant in writing within one (1) business day. The IRO must terminate its review upon receipt of this notice.

If no new information is received, the IRO will proceed with the External Review that must be a "de novo" review – i.e., a review that does not give deference to the Plan's decision. Where the information is available and appropriate, the IRO will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals;
- Other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan (to ensure that the IRO's decision is not contrary to the Plan's terms);
- Practice guidelines including evidence-based standards and others developed by the Federal government or professional medical societies, boards or associations;
- Clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer(s).

IRO Decision:

The IRO must provide written notice of its External Review decision no later than 45 days after it receives the request for the External Review. The notice must be provided to both the claimant and the Plan and must include:

- A general description of the reason for the review request with enough information to identify the claim -- e.g., the date(s) of service, name of the health care provider, the claim amount, diagnosis code (including the meaning of the code), and the general reason for the Plan's adverse benefit determination;
- The date the IRO received the request for External Review;
- The date of the IRO's decision;
- References to the evidence or documentation the IRO considered in making its decision;
- The principal reason(s) for the decision, including the rationale and any evidence- based standards used;
- A statement that the determination is binding (except where the Plan or claimant have other legal remedies available);
- A statement that judicial review may be available to the claimant; and
- Current contact information (including phone number) for any available office of health insurance consumer assistance or ombudsman.

The IRO's decision is generally binding. The claimant may still have the right to pursue a judicial review (e.g., sue the Plan). The Plan may also have the right to pursue a judicial review, but may not deny or delay payment pending judicial review.

The IRO must keep appropriate records of the review materials and its decision for six years.

Expedited External Review for Urgent Care Claims:

Expedited Reviews are required for urgent care claims.

The Plan must permit the claimant to request an Expedited External Review when the claimant receives:

- An adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the claimant's life, health or the ability to regain maximum function and the claimant has requested an expedited internal appeal; or
- A final internal adverse benefit determination if: **(1)** it involves a medical condition for which the time frame for completion of a standard external review would jeopardize the claimant's life, health or ability to regain maximum function, or **(2)** if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility.

The Plan must conduct a preliminary review to determine that the claim is eligible for External Review (step (g) (i) above) and immediately send notice to the claimant. The Plan must assign the IRO and transmit the required information to the IRO electronically, by phone, by fax or other available expeditious method. The IRO must follow the standard review process (step (g) (ii) above) including the "de novo" requirement. The IRO must provide notice of its decision as expeditiously as the claimant's medical condition requires. In all cases, the decision must be made no more than 72 hours after the IRO receives the request for an Expedited External Review. Because of the shortened time frames, the IRO may provide notice of its decision orally (e.g., via phone), but must then also provide written confirmation of the oral notice with 48 hours.