PREMIER PROVIDER NETWORK, INC.
The Premier Provider Network, Inc. (PPNI)
11111 Richmond Ave., Suite 243
Houston, Texas 77082

Provider Grievance Policy

Introduction

PPNI encourages its providers to resolve any complaints or grievances through the procedures outlined in this Grievance Policy. Grievances may be filed, and grievance forms can be obtained, by mail, fax, telephone, or online as outlined below. If filing by mail or fax, please use the Grievance Form enclosed in your provider packet or print the form posted on the web.

- If by mail, to PPNI, Attention: Sam Hamadeh, Director of Quality Assurance – Grievances, 11111 Richmond Avenue, Ste. 243, Houston, Texas 77082.
- If by fax, submit the completed form to **(713) 414-4953**.
- If by telephone, call **(866) 776-4872**.
- If via the Internet, complaints can be e-mailed to: compliance@familycarecard.com or the Grievance Form can be also be completed and submitted online at **www.ppnusa.com**.

PPNI's Grievance Policy addresses the linguistic and cultural needs of its provider population, as well as the needs of providers with disabilities. The system ensures all providers have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency, or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate. Providers may file a grievance under this Grievance Policy for up to one hundred and eighty (180) calendar days following any incident or action which gives rise to the Provider's dissatisfaction.

PPNI is responsible for and will resolve service-related problems, including availability and accessibility of providers, pricing or billing disputes, the sales process, and other service-related problems. PPNI is not responsible for resolving quality of care-related issues or providing medically necessary healthcare coverage to providers. PPNI will assist providers in identifying and contacting the appropriate state professional licensing agency to report quality of care–related problems (e.g. the Medical Board, Dental Board, Department of Health Services, etc.) PPNI investigates all grievances and will take all necessary steps to resolve any and all grievances including refunding provider fees as appropriate. Our provider materials describe our complaint resolution procedure and time frames for handling all complaints or grievances.

Documentation

1. PPNI will maintain a written record of each grievance submitted under this Grievance Policy. The written record shall include: the date the grievance was received; the name of the PPNI representative that processed the grievance; a summary or other documents explaining the nature of the grievance, how the grievance was handled, and a summary of the resolution.
2. PPNI will retain copies of grievances, responses, and resolutions for five years. When applicable the records shall contain all documents, evidence and other relevant information upon which PPNI relied in reaching its decision.
3. Grievance forms shall be available as outlined above. Additionally, PPNI will have the Grievance Policy and Grievance Forms posted on its web sites and included in the provider packets and provider packets, so that providers will have access to these forms in their initial packet as well as at each contracting provider's office or facility.
4. Grievances filed under this Grievance Policy shall not affect the provider's status in any way. PPNI will enforce a strict no-tolerance policy against discrimination based upon the filing of a grievance under this Grievance Policy.
5. Providers may file a grievance under this Grievance Policy for up to one hundred and eighty (180) calendar days following any incident or action which gives rise to the provider's dissatisfaction.

Response & Resolution

1. Grievances received under this Grievance Policy shall be acknowledged by an oral and/or written response. The response will advise the provider that their grievance has been received, the date of receipt, and provide the names of PPNI's department and representative, and telephone number and address of the PPNI representative who may be contacted about the grievance. All grievances will be resolved within thirty (30) calendar days from submission and will be reviewed from time to time by PPNI's officers and governing body to identify patterns regarding grievances as presented by the applicable management and supervisory staff. A clear and concise response with the results of the investigation to the provider will be provided within thirty (30) calendar days in writing.
2. Notwithstanding section one (1) above, grievances received by telephone that are resolved by the close of the next business day, will not be answered by written acknowledgment and response unless otherwise required by law. PPNI shall maintain a log of all grievances that do not require a written

acknowledgement containing the date of the call, the name of the complainant, provider identification number, nature of the grievance, nature of resolution, and the PPNI representative's name who took the call and resolved the grievance. PPNI shall periodically review the information contained in this log.

3. Grievance reports will be shared quarterly with the appropriate management and supervisory staff responsible for the grievance to ensure provider concerns are addressed.

Grievance Tracking & Reporting

1. PPNI, through its responsible representatives, shall monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the provider or PPNI; and the number of grievances pending over thirty (30) calendar days. PPNI will distinguish complaints by whether a Provider grievance is pending at: (1) PPNI's internal grievance system; (2) the applicable State Regulatory Authority complaint process; (3) the applicable State Regulatory Authority Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process.
2. PPNI will track the total number of grievances received, pending and resolved in favor of the provider at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) complaints about access to care (including complaints about the waiting time for appointments), and (3) complaints about the quality of service, and (4) other issues.
3. PPNI is not responsible for resolving quality of care-related issues or providing medically necessary healthcare coverage to providers. PPNI will assist providers in identifying and contacting the appropriate state professional licensing agency to report quality of care–related problems (e.g. the Medical Board, Dental Board, Department of Health Services, etc.)
4. PPNI marketers must submit all grievances to PPNI within three (3) business days. All such grievances shall be handled in accordance with this policy.

Submission of Reports

1. If applicable, a report shall be submitted to the appropriate State Regulatory Authority describing grievances that were or are pending and unresolved for thirty (30) days or more. The report shall also contain the number of grievances referred to external review processes, such as the applicable State Regulatory Authority's complaint or Independent Medical Review system, or other external dispute resolution systems, known to PPNI.
2. The report filed by PPNI shall include:
   - A PPNI's name, period report covers, and date of the report;
   - B The total number of grievances filed by providers that were or are pending and unresolved for more than thirty (30) calendar days at any time during the reporting period; A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) Family Care's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes;
   - C A brief explanation of why the grievance was not resolved in thirty (30) days, and indicate whether the grievance was or is pending at: (1) PPNI's internal grievance system; (2) the applicable State Regulatory Authority's consumer complaint process; (3) the State Regulatory Authority's Independent Medical Review system; (4) court; or (5) other dispute resolution processes;
   - D The nature of the unresolved grievances listed as either (1) coverage disputes; (2) complaints about access to care (including complaints about the waiting time for appointments); (3) complaints about the quality of service; and (4) other issues. All issues reasonably described in the grievance shall be separately categorized.
   - E The report shall not contain personal or confidential information with respect to any provider.
   - F The report shall contain the necessary information as prescribed by the applicable State Regulating Authority.
3. Prior to submitting the report to the applicable State Regulatory Authority, the Report shall be verified by an officer authorized to act on behalf of PPNI.
4. PPNI's grievance reports shall be filed as prescribed by the applicable State Regulatory Authority.

State Specific Regulations

California

As a part of its Grievance Policy, PPNI will send an Annual Notice of Grievance Procedures to its providers informing them of the California Department of Managed Health Care's ("Department") review process, the Department's toll-free number and website, as well as PPNI's Grievance Policy.

Grievances received under this Grievance Policy shall be acknowledged by written response within five (5) calendar days.

Quarterly Reports Submitted to the Department

A quarterly report shall be submitted to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to PPNI as of the last day of each quarter.

The quarterly report filed by PPNI shall include:

- A PPNI's name, quarter and date of the report;
- B The total number of grievances filed by providers that were or are pending and unresolved for more than 30 calendar days at any time during the quarter;

C A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) PPNI's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes;

D The nature of the unresolved grievances listed as either (1) coverage disputes; (2) complaints about access to care (including complaints about the waiting time for appointments); (3) complaints about the quality of service; and (4) other issues. All issues reasonably described in the grievance shall be separately categorized.

E The quarterly report shall not contain personal or confidential information with respect to any provider.

Prior to submitting the quarterly report to the Department the Report shall be verified by an officer authorized to act on behalf of PPNI. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to PPNI's application.

PPNI's grievance reports shall be filed quarterly with the Department in the form specified by California law.

Provider's Right to Submit Grievance Directly to the Department

Notwithstanding the Grievance Policy above, after completion of the grievance processes described above or participation in those processes for thirty (30) days, PPNI providers have the right to submit grievances directly to the Department by calling **(888) 466-2219** or TDD line **(877) 688-9891** for the hearing and speech impaired, or by visiting **www.hmohelp.ca.gov**. PPNI providers must complete or participate in PPNI's grievance process for at least thirty (30) days before they may submit their grievance to the Department of Managed Health Care for review. However, in any case determined by the Department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the Department determines that an earlier review is warranted, a subscriber or provider shall not be required to complete the grievance process or to participate in the process for at least thirty (30) days before submitting a grievance to the Department for review.

Upon notification from the Department that a consumer has filed a grievance, PPNI will provide the following documents to the Department within five (5) calendar days:

A A written response to the issues raised by the grievance.

B If the grievance was first filed with PPNI, a copy of PPNI's original response sent to the provider regarding the grievance.

C A complete and legible copy of all factual records related to the grievance.

D All other information used by PPNI or relevant to the resolution of the grievance.

E Any other information deemed necessary and appropriate by Family Care's management for the resolution of the grievance.

Texas

All grievances/complaints shall be acknowledged by written response within five (5) business days.