Member Complaint Instruction

Resolution Procedures: Member shall contact UDC Dental California Inc., (the Plan) or Plan Provider regarding any inquiries, or complaints (also referred to as grievances). In addition to contacting the Plan, Members should forward any question or concern directly to the Provider rendering service to resolve the issue immediately. Inquiries or dissatisfactions may be sent to the Plan by telephone or in writing.

Definition: A "complaint" is defined by the Plan, as well as under California law as a written or oral expression of dissatisfaction regarding the Plan and/or Plan Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member's representative. In cases where the Plan is unable to distinguish between a "complaint" and an "inquiry," it shall be considered a complaint.

Assistance with filing a complaint: The Plan ensures that all members 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 includes, 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. This assistance is available by contacting the Plan at (800) 443-2995.

A. Verbal Complaints:

Member may contact Plan customer service department regarding any inquiry, complaint or grievance that cannot be resolved to Member's satisfaction. This occurs after speaking directly with the dentist or other concerned party. A Plan customer service representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan customer service representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed. **Complaint forms are also available on our web site,** www.udcdentalcalifornia.com.

B. Written Complaints:

Member may complete a complaint form or other similar correspondence describing his or her dissatisfaction with service or care delivered by Plan or Plan Dentist. Plan will acknowledge the written complaint within five (5) business days by notifying the complainant in writing. Plan will investigate the complaint and will provide a written resolution to Member within (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted.

C. Appeal Procedure:

If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Plan's assessment. Upon receipt of an appeal request, Plan will provide Member with Plan's written appeal process as defined by Plan or in accordance with applicable state law.

D. Complaints Regarding Emergency Dental Services:

Notwithstanding any provision in the Agreement to the contrary, investigation and resolution of complaints regarding presently occurring Emergency Dental Services shall be concluded in accordance with the immediacy of the case and shall not exceed twenty-four (24) hours from receipt of Member's complaint.

Members may also file a complaint with the California Department of Managed Health Care. California law sets for this right in the following statement:

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 821-1294** 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 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 on line.