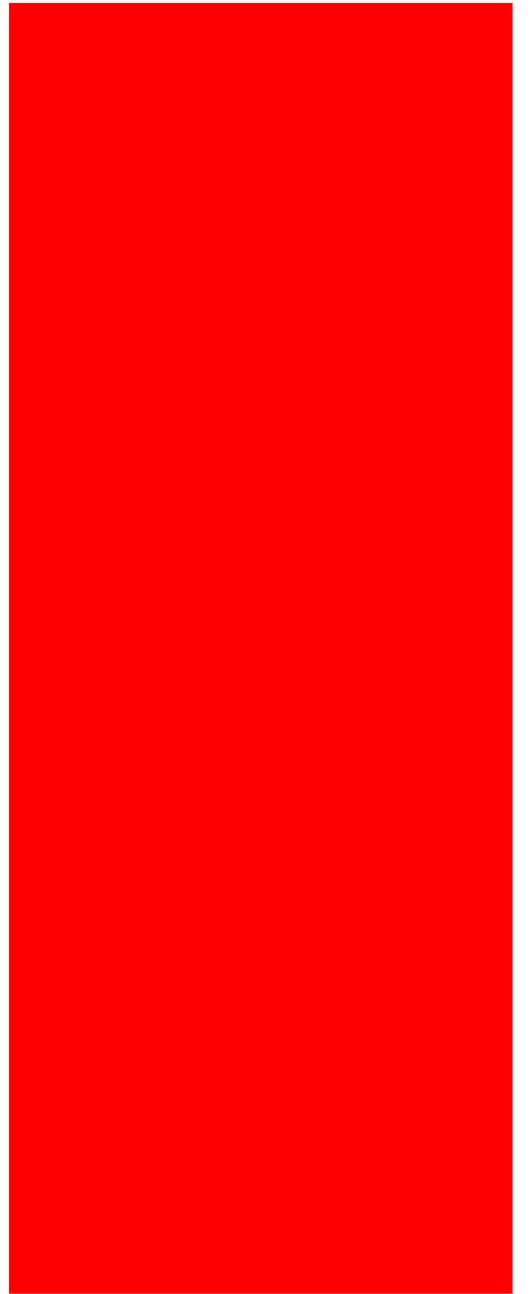


107 SECTION N –  
GRIEVANCE AND  
APPEALS

108 N.1



## Section N: Grievances and Appeals (Section §13 of RFP)

**N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:**

- **Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;**
- **Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and**
- **Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.**

**Include in the description how data resulting from the grievance system will be used to improve your operational performance.**

### Grievance System

At Aetna Better Health<sup>®</sup>, we believe that member grievance and appeal processes are key for protecting the rights and health of our members and for improving our program operations and management. Our grievance and appeal processes will be simple and user-friendly and as such, afford members the opportunity to voice their issues, concerns and problems in a way that is comfortable for the member. The process is readily available to our members and we welcome the opportunity to help them resolve issues and concerns. Our approach, to identify and resolve grievances and appeals quickly, is designed so that our members, regardless of racial, ethnic and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner. Aetna Better Health will design its grievance system to meet Department of Health and Hospitals (DHH) turnaround times and protect confidentiality and privacy of our members and the security of our members' Protected Health Information (PHI). Additionally, our grievance system responds to and supports all member requests for state fair hearings.

In accordance with DHH regulatory requirements, Aetna Better Health will base its grievance system on written Policies and Procedures (P&Ps), and protocols that are updated at least annually or as necessary due to changes in regulation. We will submit all proposed changes to our grievance and appeals processes to DHH for approval prior to implementation. Members are then notified at least thirty (30) calendar days in advance of any changes in Aetna Better Health's grievance or appeals policies, when possible.

Aetna Better Health's Grievance System Manager will maintain responsibility for our grievance and appeals processes. This position will report to the Director of Operations. These employees will work with other Aetna Better Health Departments to resolve member grievances and appeals and will participate in training our employees on member grievance and appeal rights, the grievance and appeal process and timeframes, and how to assist members in filing a grievance or appeal. We will provide initial and ongoing training on our member and provider grievance and appeal processes to key health plan personnel (e.g., Medical Management, Provider Services,

and Member Services). The purpose of this training is to provide our personnel with the necessary information to enable them to facilitate resolution of complaints, grievances, and appeals processes and to assist members and providers who want to file a complaint, grievance, or appeal. This training is combined with an effective health literacy and cultural competency training program that educates on cultural and linguistic requirements of health care and service delivery, member ethnicity and languages spoken, and the impact on health outcomes related to racial and ethnic disparities.

Aetna Better Health maintains an internal, proprietary application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. This affords us the means to address not only issues affecting individual member and provider satisfaction, but potential trends in the delivery system as a whole, permitting health plan personnel to take prompt, corrective steps to minimizing risks to performance standards. The Grievance System Manager is responsible for maintaining the Grievance and Appeals database, including training personnel on how to utilize the database and monitoring entries for completeness and accuracy. Aetna Better Health routinely generates monthly, quarterly and annual member grievance and appeal reports that allow us to identify deficiencies or patterns in specific program areas or among certain providers, and we will use the information as a management tool to help guide redesign, monitoring and improvement activities for our programs. With these reports, we are able to monitor the trends in volume and types of grievances and appeals, volumes by grievance and appeal levels, and volumes of appeals overturned and the analysis for the over-turned appeals. The Grievance and Appeals database also supports our electronic submission of monthly grievance and appeals to DHH that include 1) the member's name and Medicaid number, 2) summary of grievances and appeals; 3) date of filing; 4) current status; 5) resolution and resulting corrective action; and 6) any other information requested by DHH.

Aetna Better Health maintains two inter-departmental and cross-functional committees to review grievances and appeals: 1) the Grievance Committee, and 2) the Appeals Committee. Our Grievance Committee will be responsible for reviewing grievances filed by members and identifying opportunities for improvement by reviewing grievance management reports. The Grievance System Manager chairs the committee, which is composed of the Medical Director, Compliance Officer, Representatives from our Member Services, Quality Management, Medical Management, Utilization Management, and Provider Services Departments, a member representative and, if required, a representative of DHH. If a grievance that is brought to the Committee is related to a clinical issue then a provider of the same or similar specialty not involved in any prior decision-making on the issue must make the decision regarding the grievance.

The Appeals Committee is responsible for reviewing appeals made by Aetna Better Health members. The committee is chaired by the Grievance System Manager and includes the Medical Director or a designee, the Compliance Officer and representatives from our Quality Management and Utilization Management Departments, and a staff nurse or physician with the same specialty as appropriate. None of the voting members on the committee will have been involved in the original appeal decisions.

### **Educating Members and Providers about Grievance and Appeals Process**

Members or members' families/caregivers or providers may file grievances and/or appeals either verbally by contacting the Member Services Department or by submitting a request in writing with the member's written consent designating them as the representative. Unless the member is requesting an expedited appeal resolution, a verbal appeal request is followed by a written, signed appeal. Aetna Better Health will advise members of their appeal rights in the member handbook, the Notice of Action letter and the Appeal Decision Letter. The member handbook includes information on appeal procedures and timeframes, including:

- The requirement and timeframes for filing an appeal.
- The availability of assistance in the filing process.
- The toll-free numbers that the member can use to file an appeal by phone.
- The procedures for exercising the rights to appeal or request a State fair hearing.
- That the member may represent himself or use legal counsel, a relative, a friend, a provider or other spokesperson.
- The specific regulations that support or the change in Federal or State law that requires the action.
- The fact that, when requested by the member -
  - Benefits will continue if the member files an appeal or a request for a State fair hearing within the timeframes specified for filing; and
  - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

Our Member Handbook includes the following information about the member's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted:

- A member or a representative acting on their behalf may request a State fair hearing within thirty (30) calendar days from the health plan's notice of action.

It is Aetna Better Health's policy that our written and verbal communication with members is respectful and reflects the individuality of the members that we serve, consistent with DHH's Person First policy. All written documents from Aetna Better Health relating to a grievance will be written at the appropriate grade level, with notations that the information is also available in Spanish or Vietnamese and other prevalent languages (spoken by 200 or more members) at no cost to the member. We will also state that oral interpretation services are available by calling Member Services. We also provide materials and information using alternative communication mechanisms such as Braille and audiotapes, upon request. Oral interpretation services are available at no cost to members at the fair hearing, including sign language, and reasonable accommodations will be provided. Our Member Services Department provides members any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services through the Language Line and toll-free numbers that have adequate TTY/TTD and interpreter capability. Aetna Better Health's Member Services Representatives will be trained to assist all members, including members with special health care needs to navigate the grievance and appeals process.

Aetna Better Health provides clear guidance and instructions to providers regarding our process for making decisions regarding requested services. We distribute information regarding the grievance and appeals process to all in-network providers at the time they enter into a contract with Aetna Better Health. Out-of-network providers receive a copy of the member flyer outlining the processes within ten (10) calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier.

### **Member Grievances**

For issues related to matters failing to meet the definition of an action (an appeal) that are filed by a member or their representative, including a provider authorized in writing to act on the member's behalf, Aetna Better Health will follow the grievance procedure. A grievance may be filed with Aetna Better Health either verbally or in writing.

The Grievance System Manager has primary responsibility for coordinating, managing, and resolving member grievances and for disseminating information to members about their grievance rights. Aetna Better Health executives with the authority to require corrective action are also involved in the grievance process. If a grievance requires research or input by another department, the Grievance System Manager will forward the information to the affected department. The affected department will thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions along with Aetna Better Health's written policies and procedures, and collects pertinent facts from all parties. The Grievance Committee will consider the additional information and resolves the grievance. Grievance resolutions are then added to the Appeals and Grievance Database.

When a Member Services Representative (MSR) or other employee receives a grievance, either in person or by telephone, letter, or e-mail, the employee will document the grievance in the call system and forward it to the Grievance System Manager for review and resolution. Each grievance will be assigned a grievance category type (e.g., accessibility/availability, cultural barriers/insensitivity, etc.). The employee receiving the grievance will acknowledge the grievance verbally when it is received. Aetna Better Health will send a written acknowledgement to the member and their authorized representative or designee within five calendar days of receipt of a verbal or written grievance.

Aetna Better Health will process two types of member grievances: 1) denial of expedited processing time for an appeal, and 2) service or quality grievance. The process for recognizing, receiving, managing and resolving both types of member grievances is described below.

**Denial of expedited processing time for an appeal** received from members or their authorized representative, if designated. If a member requests expedited processing of an appeal and it does not meet the criteria for expedited processing, the expedited processing time is denied and the appeal is processed within the standard appeal timeframe. Upon receipt of the denial for expedited processing, members or their authorized representative (if designated) can file a grievance based on this denial. These grievances are processed according to the expedited processing time.

**Service grievances** received from members or their authorized representatives include, for example, members' dissatisfaction with the consistency of services, but do not involve clinical/quality concerns. Typically, the MSR, based on their training and experience, will be

able to resolve these grievances immediately. If an immediate resolution will be impossible, the employee receiving the grievance will verbally inform the member and/or their authorized representative that additional research will be necessary and that the member or member's family/caregiver can expect a resolution within ninety (90) calendar days and forward the grievance to the Grievance System Manager. The Grievance System Manager will acknowledge all quality of service grievances in writing within 3 business days and will complete a potential quality of care or service referral form to the Quality Management (QM) Department for review and investigation. Upon resolution, the QM Department will notify the Grievance System Manager within ninety (90) calendar days that the issue will be closed and to send a response letter.

**Quality grievances** received from members or their authorized representatives involve issues related to quality of care or treatment (e.g., alleged inadequate medical care). After documenting the quality grievance in the call system the grievance is forwarded to the Grievance System Manager. If the grievance is a potential quality grievance, the Grievance System Manager on the same day will complete a quality of care or service referral form to the QM Department for review and investigation. The Grievance System Manager will acknowledge all quality of service grievances in writing within three (3) business days. Clinically trained QM review nurses and the designated Medical Director research and resolve these grievances (involving the Peer Review Committee, if appropriate). Upon resolution, the QM Department will notify the Grievance System Manager within ninety (90) calendar days that the issue will be closed and to send a response letter.

Aetna Better Health will make sure that individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and who, if deciding a grievance regarding denial of expedited resolution of an appeal or a grievance that involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease.

Aetna Better Health will resolve all grievances and provide notices to affected parties within ninety (90) calendar days from the date of receipt. We will notify members in writing of the outcome of the investigation of the grievance within two (2) calendar days of its resolution using the method prescribed by DHH.

At no time will Aetna Better Health initiate disenrollment because of a member's attempt to exercise his or her rights under the grievance system, and we will not take punitive action against a provider who files a grievance or supports a member's grievance.

### **Member Appeals**

Aetna Better Health will provide members or their authorized representative, if designated, with information regarding their right to appeal adverse actions taken by Aetna Better Health. A member may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized member representatives, including providers, may also file an appeal on the member's behalf with the written consent of the member. All appeals must be filed no later than thirty (30) calendar days from the postmark on the Aetna Better Health *Notice of Action* letter. The expiration date to file an appeal is included in the *Notice of Action*.

In most cases, a decision on the outcome of the appeal will be reached within thirty (30) calendar days. If we are unable to resolve an appeal within thirty (30) calendar days, we may ask to extend the appeal decision date by 14 calendar days. In these cases, we will provide information describing the reason for the delay in writing to the member and, upon request, to DHH.

Aetna Better Health will execute the appeal process with utmost regard to protecting the confidentiality of any protected health information gathered through the process. The appeals process will follow our privacy policies, which comply with HIPAA requirements.

Throughout the appeal process, Aetna Better Health will continue the member's benefits if the member or the provider files a timely appeal; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests an extension of the benefits. The appeal is considered to be timely if it is filed within ten (10) calendar days of the health plan mailing the notice of action and before intended effective date of the health plan's proposed action.

#### ***Standard Appeals Process***

Aetna Better Health's Grievance System Manager will receive all appeals, assign each appeal a tracking number, log the appeal information into the Appeals Database, and create a file including all related documentation. Aetna Better Health will acknowledge each appeal in writing within three (3) business days of receipt.

The Grievance System Manager will conduct a thorough investigation of each appeal by reviewing the substance of the appeal request; the initial adverse action notes and records; additional clinical information and documentation submitted by the member, their authorized representative, or the member's physician or treating provider; all aspects of clinical care involved; and specialty reviewer comments. For appeals related to service denials based on lack of medical necessity or involving clinical issues, the appeal will be routed to the Chief Medical Officer (CMO) or designated Medical Director who was not involved in any previous level of review or decision-making and who has the appropriate clinical expertise to treat the member's condition or issue.

Unless an extension is granted, the Appeals Coordinator will render a decision on 100 percent of appeals within thirty (30) calendar days of the appeal receipt date. An extension will grant an additional fourteen (14) calendar days from the date of appeal receipt. If the timeframe is extended for a reason other than the member's request, Aetna Better Health will provide the member with notice of the reason for the delay.

#### ***Pre-Service/Post-Service Appeals Process***

Upon receipt, each appeal request will be assigned a tracking number, which the Grievance System Manager will use to monitor each appeal throughout the research and resolution process. All appeals will be logged and tracked in Aetna Better Health's Appeals and Grievance database. Within three (3) business days of receiving the written appeal, the Grievance System Manager will send an acknowledgement letter to the member, their authorized representative and the member's provider. The letter will provide information about their appeal rights and include a request for any additional clinical documentation that could support the services requested.

The member and their authorized representative if designated will be given the opportunity to present supporting documentation or evidence in person or in writing on or before the date of the appeal meeting date. The member or their authorized representative if designated may also contact the Grievance System Manager to ask to review the member's file or clinical records that will be reviewed before and/or during the appeals process.

After the appeal request and all supporting documentation are received the appeal is reviewed by individuals who were not involved in the initial determination and are not a subordinate of any person involved in the initial determination. All appeals will be reviewed by an appropriately licensed practitioner who was not involved in the initial determination and is not the subordinate of any person involved in the initial determination. This practitioner must be Board eligible or certified as required, have clinical expertise in the same or a similar specialty, and typically treat the medical condition or perform the procedure.

During the review, the information documented will include:

- The substance of the appeal request, including a short, dated summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution,
- The initial adverse action notes and records,
- Additional clinical information and documentation submitted by the member, member's representative, member's practitioner and/or member's provider,
- All aspects of clinical care involved,
- The specialty reviewer's (the specialty reviewer not involved in the initial determination and not a subordinate of any person involved in the initial determination) comments.

When a decision is reached, it will be approved and signed by the health care professional making the decision or their designees.

### ***Expedited Appeals Process***

Aetna Better Health will resolve all appeals effectively and efficiently. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, may occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. A member or provider may request an expedited appeal either orally or in writing within thirty (30) calendar days from the day of the decision or event in question. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf.

Upon receipt of an expedited appeal, we will begin the appeal process immediately. We will acknowledge expedited appeals at the time of receipt or by telephone if received in writing on the day the expedited request is received. Initial review of the issue will begin in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue will be transferred to the standard appeal process. We will make reasonable efforts to give the member prompt verbal notice of the denial of expedited processing time and follow up within two (2) calendar days with a written notice.

In cases where we determine a member's request meets expedited urgency or a provider supports the member's request, an appropriately licensed practitioner who was not involved in the initial

determination and is not the subordinate of any person involved in the initial determination will render a decision as expeditiously as the member's health requires, but no later than seventy-two (72) hours from the receipt of the expedited appeal request. This practitioner must be Board eligible or certified as required, have clinical expertise in the same or a similar specialty, and typically treat the medical condition or perform the procedure.

### **Appeal Decision Letter**

For pre-service and post-service appeals, once a decision is rendered, an *Appeal Decision Letter* will be sent to the member, their authorized representative if designated and the member's provider as expeditiously as the member's health requires, but not more than two (2) calendar days from the receipt of a pre-service or post service appeal request. If the decision is upheld, the *Appeal Decision Letter* will explain the next level of appeal, which is the State fair hearing option available through the State's Division of Administration – Administrative Law Judge Division (DOA-ALJD).

The written notice of the appeal resolution will include:

- The results of the resolution process and the date it was completed;
- For appeals not resolved wholly in the favor of the member, the right and process to request a State fair hearing;
- The right and process to request a continuation of benefits while the hearing is pending;
- Notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's action;
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based and notification that the member can request a copy of this information;
- Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or record relied upon and document and records submitted in the course of making the appeal decision;
- A list of the titles and qualifications of each individual participating in the appeal review, including specialty, as appropriate. Participant names need not be included in the written notification to the members, but must be provided to members, upon request;
- A description of the State fair hearing process along with any relevant written procedures;
- A description of the process to request that services continue while a State fair hearing is being processed, including that the member may be held financially liable for such services if the State upholds the denial decision

Aetna Better Health will promptly forward any adverse decisions to DHH for further review or action upon request by DHH or the Aetna Better Health member.

### **Tracking Appeals**

Upon receipt by Aetna Better Health, each appeal request will be assigned a tracking number, which the Grievance System Manager uses to monitor the appeal throughout the research and resolution process. All appeals will be logged and tracked in Aetna Better Health's Appeals and Grievance Database.

The Grievance System Manager will be responsible for managing member appeals and reports to the Director of Operations. The Coordinator's responsibilities will include documenting individual appeals, coordinating resolutions, tracking data and reviewing appeals for trends. All data will be reported to the Service Improvement Committee (SIC) and the Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate) will summarize the frequency and resolution of all appeals.

The Grievance System Manager will maintain hard copy and/or electronic images of the complete appeal records in accordance with DHH's applicable record retention policies. Full documentation of the appeal will include all components of the investigation, as well as any actions taken.

### **State Fair Hearing (SFH) Process**

The grievance system process is not a substitute for the State fair hearing process. Upon completion of the appeals process, the member and/or their authorized representative acting on behalf of the member may request a State fair hearing through the State's Division of Administration – Administrative Law Judge Division (DOA-ALJD) if it is within thirty (30) calendar days from Aetna Better Health's notice of an adverse action in the appeal decision letter. The parties to the State fair hearing will include Aetna Better Health, the member, and his or her authorized representative if designated or the representative of a deceased member's estate. Aetna Better Health will comply with decisions reached as a result of the state fair hearing process.

If we receive the request directly from the member or provider, we will forward the request to DOA-ALJD. When the request comes directly from DOA-ALJD, we will log it into our Appeals and Grievance database where it will be tracked by our Grievance System Manager. When the hearing is scheduled, we will document the date of the State fair hearing in the appeals database. Generally, Aetna Better Health's Medical Director or other applicable Aetna Better Health employees will attend the State fair hearing and offer evidence as appropriate.

If the request for a State fair hearing has been submitted within the ten (10) day filing timeframe, we will notify our Medical Management Department to continue the member's benefits, if the member wishes to do so. If the final decision is adverse to the member, the member may be required to pay the cost of services furnished while the State fair hearing was pending.

Within fourteen (14) days of receiving the member's request for a fair hearing from the DHH, we will send a copy of the member's initial adverse determination and their appeal of Aetna Better Health's action; the contents of the appeal file including research, medical records and other documents used to make our decision (i.e., a summary of the member's initial adverse determination, their appeal and the evidence we used to make our Decision); and a copy of the Appeal Decision Letter provided to the member and to DHH.

If the State fair hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, we will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If the State fair hearing Officer's decision reverses Aetna Better Health's original decision to deny, limit, or delay services, and the services were continued at the request of the member or member's

family/caregiver during the appeal; we promptly authorize the services with an effective date equal to the date of receipt of the original appeal.

### **Using Grievance & Appeals Data to Improve Operational Performance**

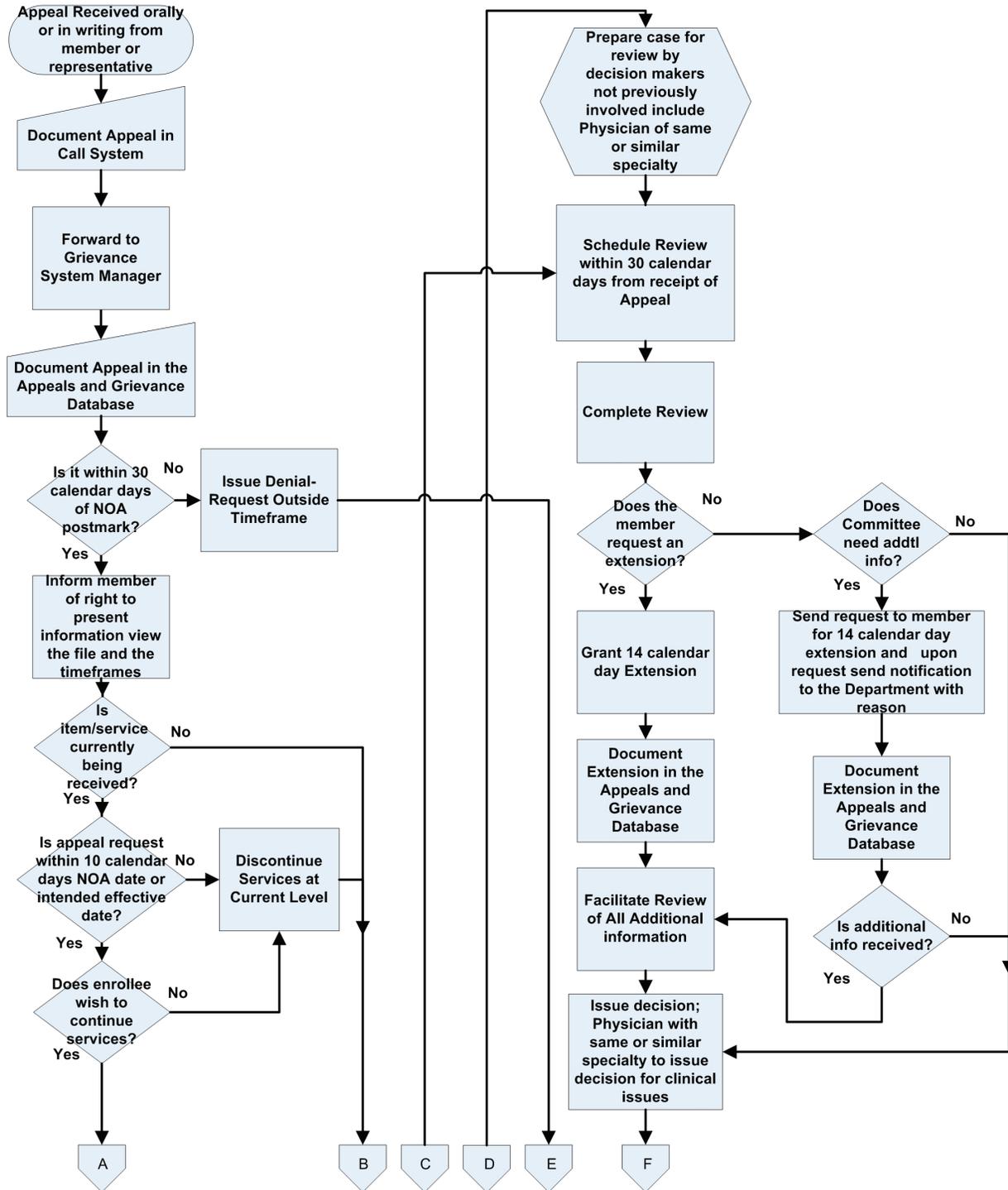
Aetna Better Health views appeals and grievances as indicators of potential process improvement opportunities. Under the direction of the Chief Executive Officer (CEO) and with support of the Director of Operations and the Grievance System Manager, data from the grievance system will be used to identify opportunities to improve provider performance and our operations (i.e., Medical Management, Claims, Provider Network, etc.). Our Grievance and Appeals Database is custom designed to capture, store, and retrieve detailed information on grievances and appeals. Using this database, Aetna Better Health will produce a suite of management reports, with capabilities to drill down to identify root causes. Additionally, as part of their quality improvement processes, other operational areas will use grievance system data results along with other data sources (e.g., provider utilization patterns, satisfaction survey results) to identify improvement opportunities.

In addition to monitoring member grievance information for timeliness, Aetna Better Health will aggregate and analyze the grievance data to identify other opportunities for improvement. Quarterly and annual member grievance reports include an in-depth analysis of grievance data, comparing trends to previous contract years and identifying opportunities for improvement. Data examined includes: 1) average number of grievances per 1,000 members, 2) types and causes of grievances, 3) timeliness of resolution, and 4) provider outliers in terms of number of grievances. This information will be captured in routine member grievance reports submitted to the Grievance and Appeal Committees and shared with the Service Improvement Committee (SIC).

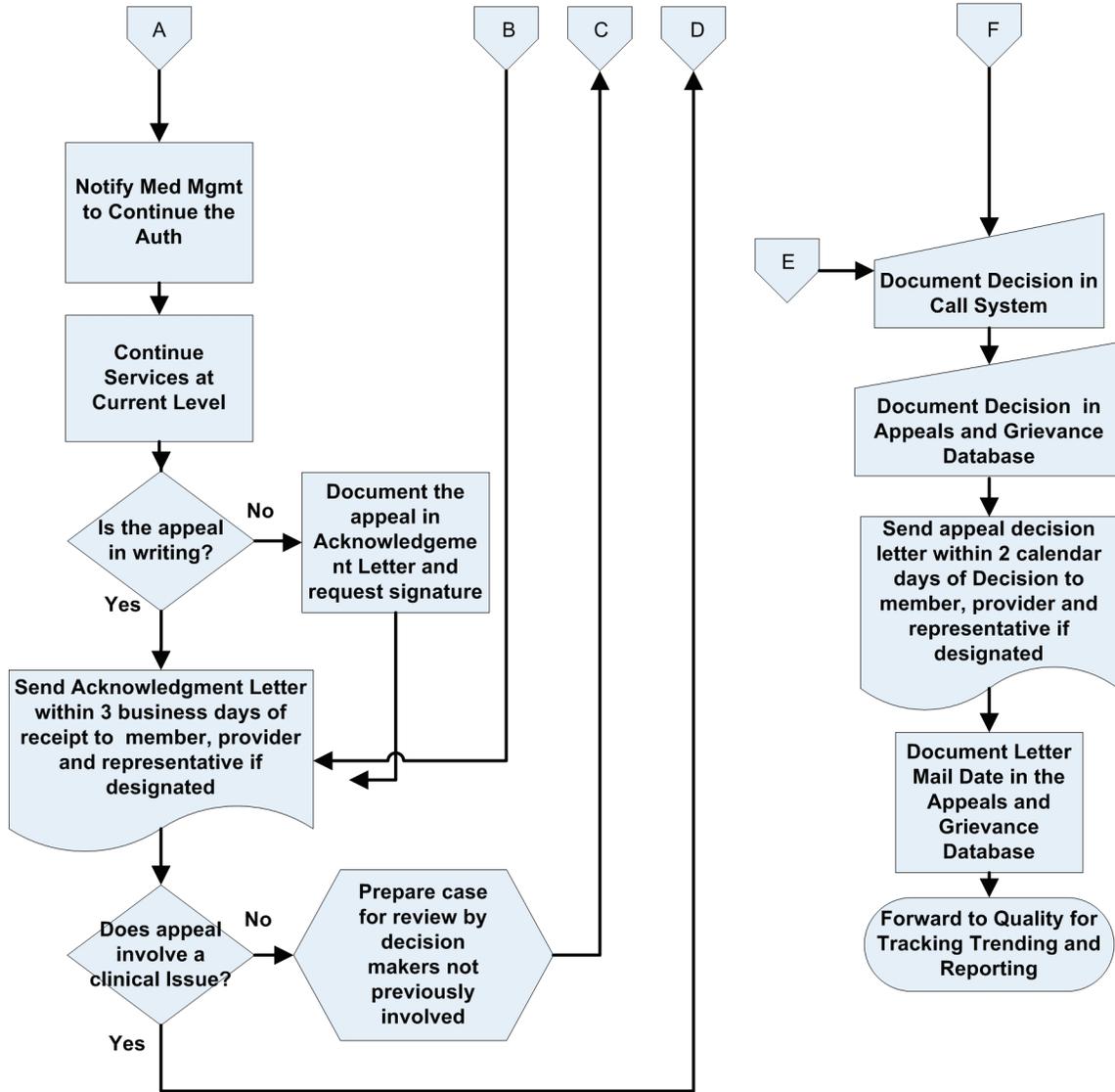
The Grievance and Appeal Committees will identify trends and root causes for grievances, appeals, and report member feedback trends to Aetna Better Health's SIC. The SIC is a multi-disciplinary committee chaired by the Director of Operations and includes the Medical Director, representatives from our Member Service, Provider Relations, Medical Management, Quality Management, and Grievance and Appeals Departments, and other departments as needed. This committee will review trended data related to member and provider complaints grievances and appeals and will make recommendations operational measures (such as prior authorization time standards, claims payment standards, customer service time standards, member enrollment and disenrollment, reconciliation). The SIC receives from Aetna Better Health's Operational, Case Management, and Medical Departments monthly, quarterly, and annual member and provider feedback, complaints, and survey results to identify patterns and trends. In addition to reviewing each report, the SIC evaluates whether the same themes appear across multiple data sources, thus allowing it to identify trends and prioritize improvement activities. The SIC reports its findings and recommendations related to monitoring activities to the Quality Management Oversight Committee (QMOC), a multi-disciplinary committee chaired by the CMO, which will provide recommendations for operational improvements as a result of its review of grievance and appeals, and other quality management indicators.

Our flowcharts for our member grievances and member appeals processes are provided on the following pages.

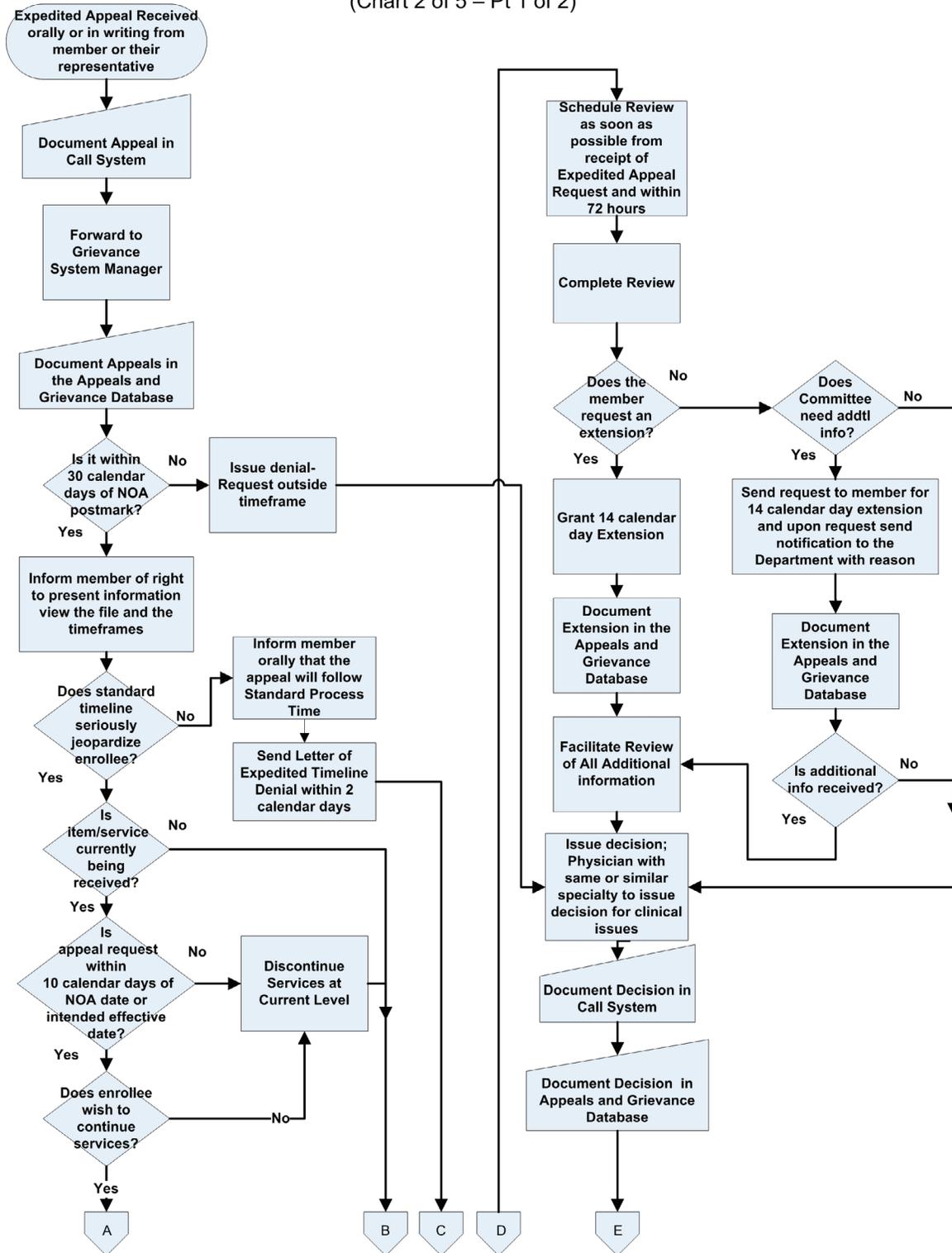
**Aetna Better Health**  
**Chart C – Appeals**  
(Chart 1 of 5 – Pt 1 of 2)



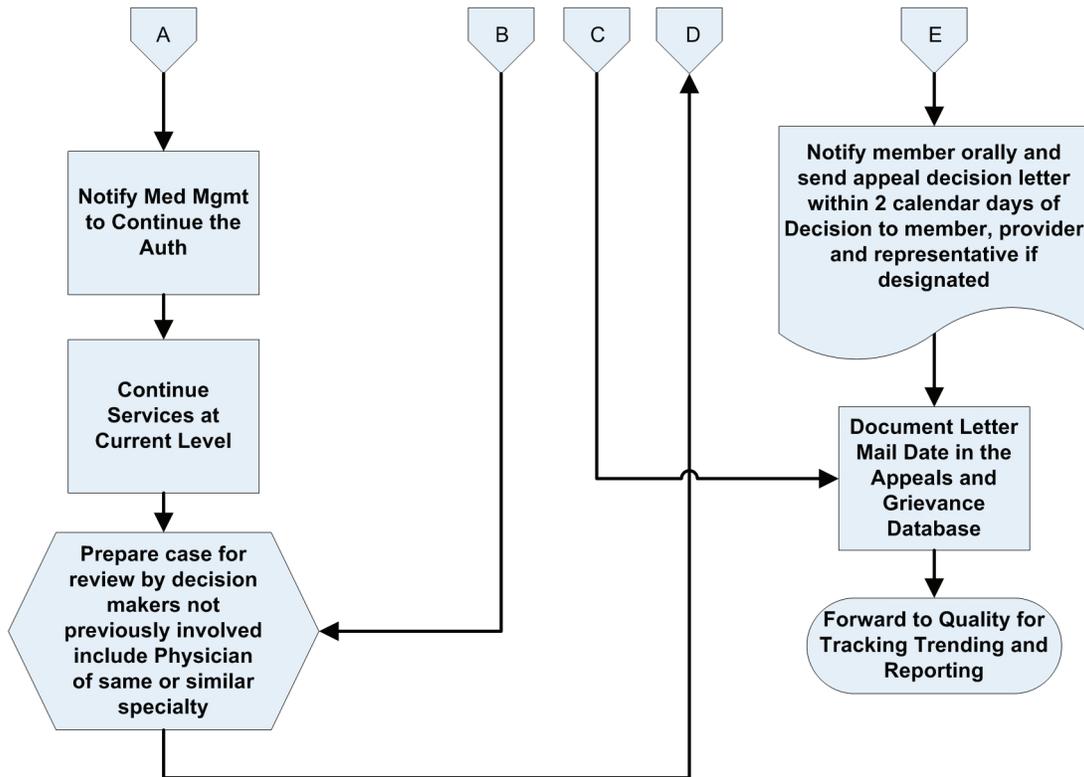
**Aetna Better Health**  
**Chart C – Appeals**  
(Chart 1 of 5 – Pt 2 of 2)



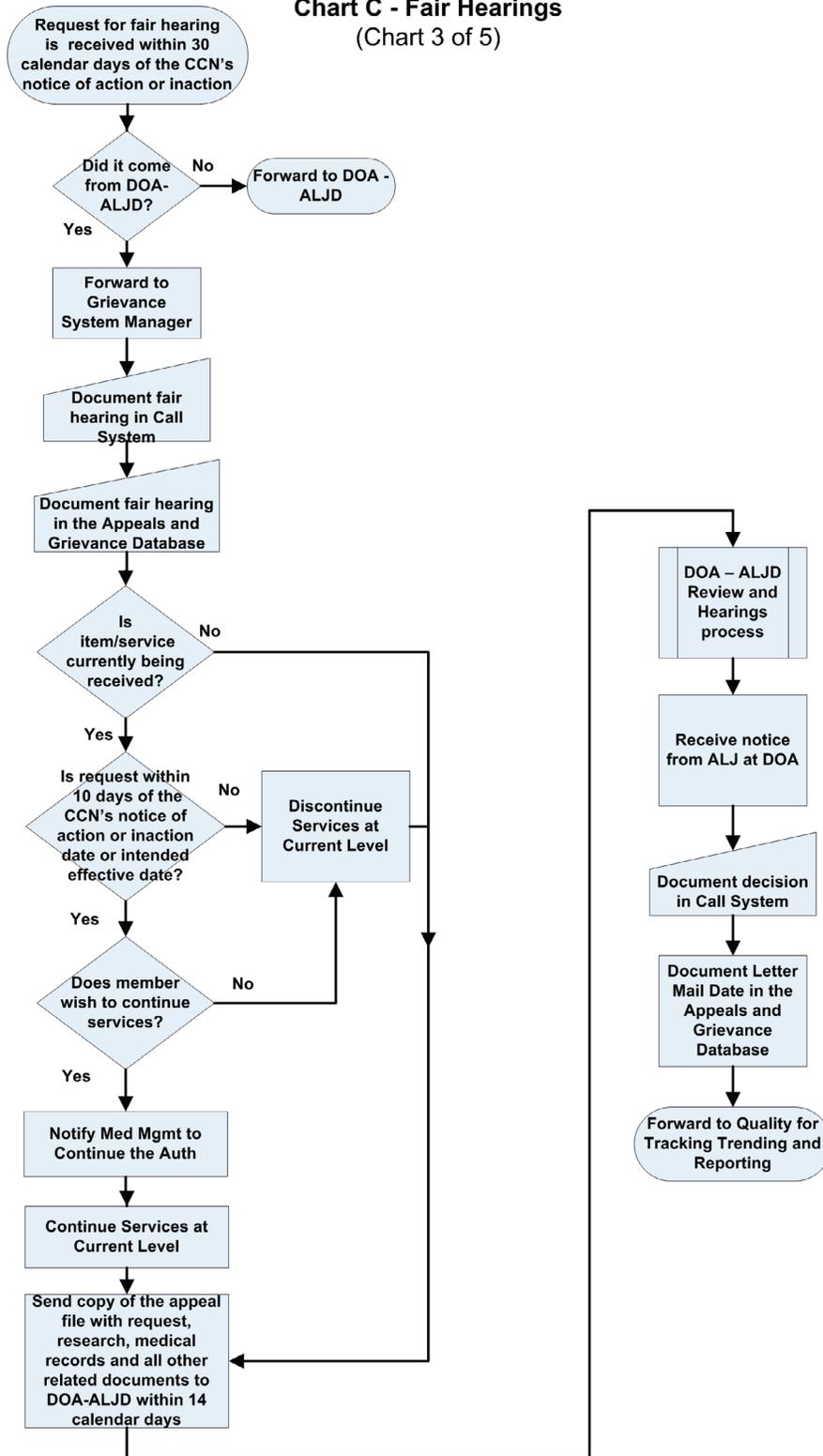
**Aetna Better Health**  
**Chart C – Expedited Appeals**  
(Chart 2 of 5 – Pt 1 of 2)



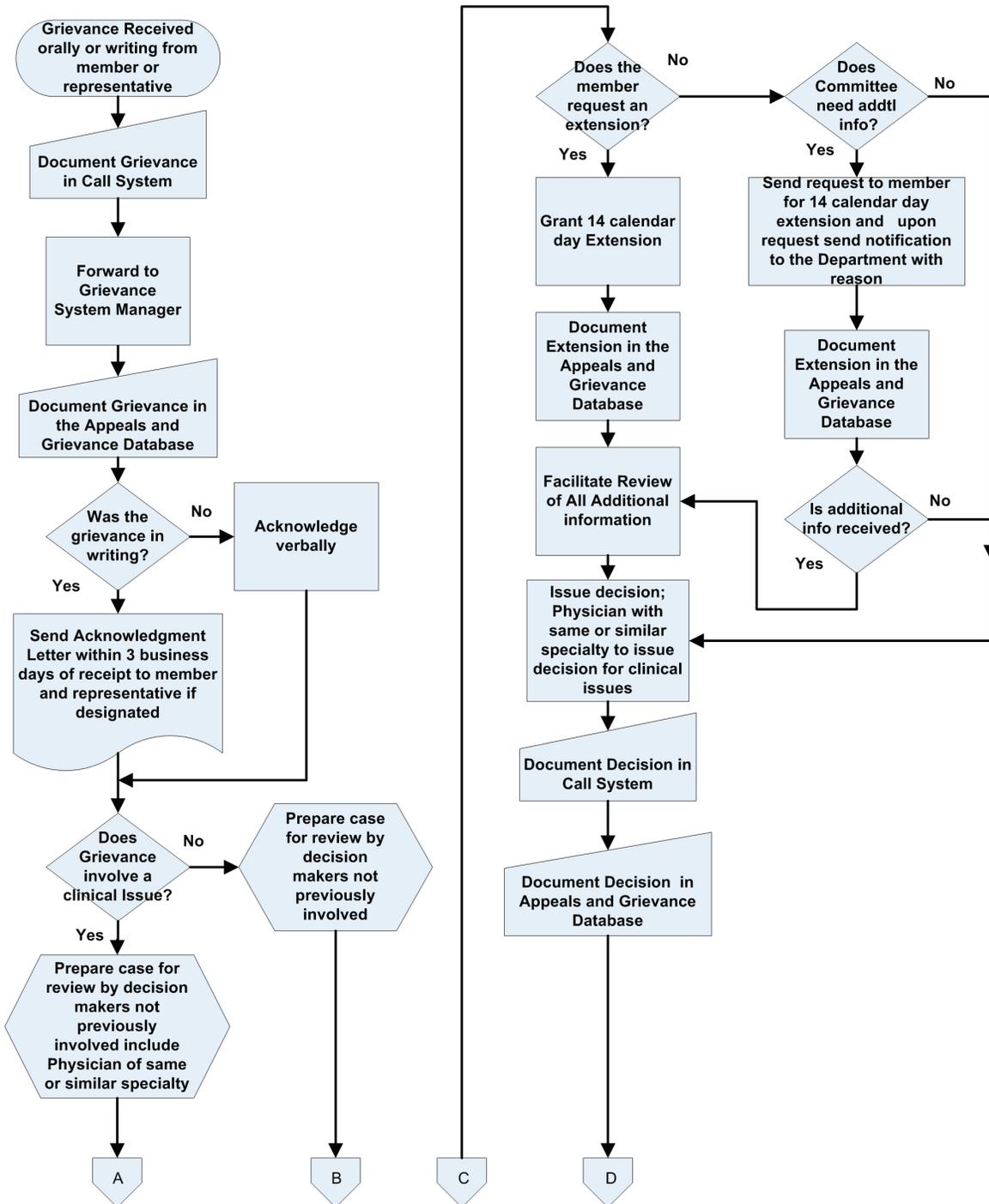
**Aetna Better Health**  
**Chart C – Expedited Appeals**  
(Chart 2 of 5 – Pt 2 of 2)



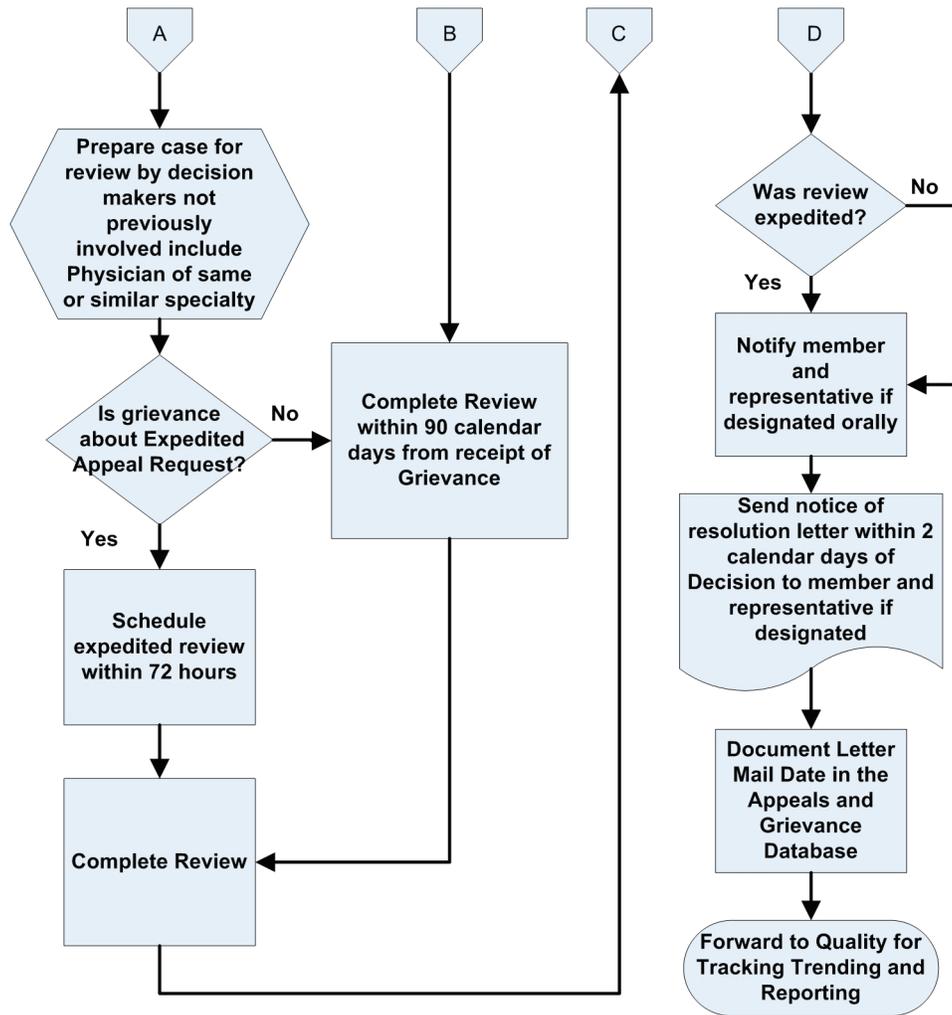
**Aetna Better Health  
Chart C - Fair Hearings**  
(Chart 3 of 5)



**Aetna Better Health**  
**Chart C - Grievances**  
(Chart 4 of 5 – Pt 1 of 2)



**Aetna Better Health**  
**Chart C - Grievances**  
(Chart 4 of 5 – Pt 2 of 2)



**Aetna Better Health**  
**Chart C – Grievance System Tracking, Trending and Reporting**  
(Chart 5 of 5)

