**Section 4520.EXHIBIT A Complaint Record and Column Descriptions**

1. Column A. Health Care Plan Identification Number – This is the identification number used by the health care plan to identify the complaint internally. The identification number must be unique for each complaint.

2. Column B. Complaint Origin – complaint was filed by:

a) Consumer or enrollee;

b) Provider;

c) Any other individual.

3. Column C. Function Code. Complaints are to be classified by functions or the health care plan involved, as follows:

a) Denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests; partial approvals and care terminations are also considered to be denials);

b) Denial of diagnostic procedure (dissatisfaction regarding prospective non-authorization of a request for a diagnostic procedure recommended by a provider; partial approvals are also considered to be denials);

c) Denial of referral request (dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a PCP);

d) Sufficient choice and accessibility of health care providers (dissatisfaction by an enrollee or policyholder regarding the extent to which the health care plan has practitioners/providers of the appropriate type and number distributed geographically to meet the needs of the member; in addition, dissatisfaction by an enrollee or policyholder regarding the extent to which the enrollee or policyholder may obtain available services at the time they are needed − available service refers to both telephone access and ease of scheduling an appointment);

e) Underwriting (dissatisfaction by an enrollee or policyholder regarding the health care plan's process of examining, accepting, or rejecting insurance risks and classifying those selected in order to charge the proper premiums for each);

f) Marketing and sales (dissatisfaction regarding solicitation or the sale of a policy by the managed care organization; solicitation means any method by which information relative to the health care plan is made known to the public for the purpose of informing or influencing potential enrollees to enroll in the health care plan, regardless of the media or technique used);

g) Claims and utilization review (dissatisfaction regarding the concurrent or retrospective evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "Denials of care or treatment," "Denials of diagnostic procedures" and "Denials of referral requests" should not be classified in this category, but the appropriate one above);

h) Member services (dissatisfaction by an enrollee or policyholder related to response time regarding provision of information; handling of a complaint, appeal or external review; or any interaction between plan representatives and enrollee);

i) Provider relations:

I) Quality of Care (dissatisfaction regarding any aspect of care provider by an institution or organization or practitioner that provides services to a managed care organization's members; this category does not include sufficient choice or accessibility of a provider);

II) Provider complaints − Prompt Pay (complaints by providers (prompt pay, etc.), excluding those filed under "Denials of care or treatment," "Denials of diagnostic procedures" and "Denials of referral request" above);

j) Miscellaneous (any "complaint", as defined above, not falling in one of the above categories).

4. Column D. Date Received – date received by the health care plan.

5. Column E. Date Closed – date closed by the health care plan.

6. Column F. Illinois Department of Insurance Complaint File Number – If the complaint was also sent to the health care plan from the Department, the health care plan should provide the IDOI complaint number in this column.

7. Column G. Illinois Department of Insurance Complaint File Closed Date. The Department will provide the company with the date the complaint was closed by the Department.

8. Column H. External Review – indicate by placing an "X" in the column if complaint was processed through external review procedure.

9. Column I. Disposition.

a) Relief Granted − If the complaint was resolved in favor of the complainant;

b) Partial Relief Granted − If the complaint was only partially resolved in favor of the complainant;

c) Information Furnished − The complaint did not require action, only information to be provided to the enrollee;

d) No Relief Granted − If the complaint was not resolved in favor of the complainant.

(Source: Amended at 38 Ill. Reg. 2253, effective January 2, 2014)