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Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

CYNTHIA HARVEY and STEVEN A. MILMAN, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

CENTENE CORPORATION, COORDINATED CARE CORPORATION, and SUPERIOR HEALTHPLAN, INC.,

Defendants.

No. 2:18-CV-00012-SMJ

CENTENE'S REPLY IN SUPPORT OF MOTION TO DISMISS

(Oral Argument: July 19, 10:00 AM)

TABLE OF CONTENTS

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TABLE OF AUTHORITIES

CASES

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OTHER AUTHORITIES

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I. Plaintiffs' Exhibits Do Not Demonstrate that this Court Has Specific Personal Jurisdiction over Centene.

Plaintiffs attempt to support their jurisdictional allegations against Defendant Centene Corporation ("Centene") with a handful of documents obtained from Washington's Insurance Commissioner. The fundamental flaw with Plaintiffs' argument is their assumption that, wherever the word "Centene" appears, there must Centene Corporation be. That assumption is neither legally nor factually justified. Moreover, none of these random documents relates to either of the Plaintiffs in this case, and Plaintiffs' claims do not arise out of these alleged contacts as would be required for specific jurisdiction to obtain.

Plaintiffs' exhibits one, two, and five purport to establish jurisdictional contacts based on the presence of "centene.com" email addresses. But the mere fact that a person has a centene.com email address does not make them an employee or agent of Centene Corp. *See, e.g.*, *Wiseman v. ING Groep, N.V.*, No. 16-cv-7587, 2017 WL 4712417, at *13 (S.D.N.Y Sept. 28, 2017) (holding that "fact that ReliaStar personnel used voya.com email addresses" did not make Voya liable for ReliaStar's acts); *Whitesell Int'l Corp. v. Amtek Auto Ltd.*, No. 13-cv-56, 2014 WL 12603144, at *4 (S.D. Iowa Feb. 19, 2014) (holding that "emails sent between individuals with 'amtek.com' email addresses" were not proof of

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jurisdiction against Amtek). In fact, the individuals mentioned in those exhibits were employees of Centene Management Company, LLC, not Centene Corp. *See* Second Decl. of Tricia Dinkelman, ECF No. 33-1 ¶¶ 6, 8 ("Reply Decl.").

As to exhibit three, that document appears to have been created by National Imaging Associates, Inc. ("NIA"), a non-affiliate that contracts to provide services to Defendant Coordinated Care Corporation ("Coordinated Care"). Centene does not tell NIA how to label its documents.

Exhibit 4 documents a request for prior authorization. A subsidiary of Centene centralizes the process of receiving these requests, but employees working on behalf of Coordinated Care ultimately handled the request. Centene is not involved in the process. Reply Decl. ¶ 7.

When fairly interpreted, none of Plaintiffs' evidence controverts what Centene maintained in its opening brief: Centene is a holding company whose board of directors oversees the Centene family of companies at a high level. As a holding company, it does not have employees in Washington. None of the individuals identified in Plaintiffs' exhibits is an employee of Centene.

Moreover, even if some of the documents were evidence of scattered contacts between Centene and Washington, none of those contacts relate to Ms. Harvey or her care. Reply Decl. ¶ 5. Only a defendant's "suit-related conduct"

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may support specific jurisdiction, *Walden v. Fiore*, 134 S. Ct. 1115, 1121 (2014), and there is no such conduct here.[1]

II. Plaintiffs Have Failed To Sufficiently Plead that Centene Is Coordinated Care's Alter Ego.

Finding jurisdiction on an alter ego basis is "an extraordinary remedy reserved for extraordinary circumstances," *Naxos Resources (U.S.A.) Ltd. v. Southam Inc.*, No. 96-cv-2314, 1996 WL 662451, at *3 (C.D. Cal. Aug. 16, 1996) (internal quotation omitted), and Plaintiffs fail to meet that high standard here. Critically, Plaintiffs' alter ego analysis omits *any* discussion of one of the two prongs of the inquiry—whether the corporate form has been misused to promote "fraud or injustice." *Ranza v. Nike, Inc.*, 793 F.3d 1059, 1073 (9th Cir. 2015) (internal quotation marks omitted). Plaintiffs have provided zero facts controverting the Defendants' evidence that Coordinated Care is managed by its own board of directors, has separate accounts, and is adequately capitalized. *See* Centene's Mem. in Supp. of Mot. to Dismiss, ECF No. 16 at 10–14 ("Opening Mem."). This is sufficient reason in itself to dismiss Plaintiffs' alter ego

[1] Although Plaintiffs make one stray reference to general jurisdiction, Pls.' Resp. to Defs.' Mots. to Dismiss, ECF No. 30 at 6 ("Resp."), general jurisdiction clearly does not apply here.

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allegations. *See, e.g., In re Western States Wholesale Natural Gas Litig.*, 605 F. Supp. 2d 1118, 1134 (D. Nev. 2009) ("Even if Plaintiffs had established a lack of corporate separateness, Plaintiffs have not established a fraud or injustice would result if the Court failed to pierce the corporate veil.").

But even as to the first prong, which asks whether the parent has exercised "*pervasive* control over the subsidiary" such that it "dictates *every facet* of the subsidiary's business," *Ranza*, 793 F.3d at 1073 (emphases added and internal quotation marks omitted), Plaintiffs' showing falls far short. Plaintiffs' allegations do not raise any inference that Centene and Coordinated Care "failed to observe their separate corporate formalities." *Id.* at 1075. Plaintiffs have done nothing more than show that Centene and Coordinated Care have a normal parent-subsidiary relationship, which is of course insufficient to show alter ego status. *See, e.g., Williams v. Yamaha Motor Co.*, 851 F.3d 1015, 1021 (9th Cir. 2017).

For instance, Plaintiffs point out that Centene's SEC filings include consolidated financial statements with its subsidiaries' results, Resp. 7–8, but they fail to mention that SEC rules and generally accepted accounting policies *require* publicly-traded parent companies to file consolidated financial statements. *See* 17 C.F.R. § 210.3-02(a). That has never been considered enough to show alter ego status. *See, e.g., Davanzia, S.L. v. Laserscope, Inc.*, No. 07-cv-247, 2007 WL

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2209323, at *5 (N.D. Cal. July 30, 2007). Moreover, Coordinated Care does prepare its own financial statements. Reply Decl. ¶ 4.

Likewise, Plaintiffs try to make much of the fact that Coordinated Care has contracted with other Centene subsidiaries like Centene Management Company, LLC ("CMC"), for the provision of various administrative functions, such as IT and claims processing. Resp. 8–10. As an initial matter, CMC is not Centene Corporation; it is a separate legal entity. Reply Decl. ¶ 9. In any event, these sorts of contracts are common and not indicative of a failure to respect the corporate form. *See In re Western States Wholesale Natural Gas Antitrust Litig.*, No. 03-cv-1431 *et al.*, 2009 WL 455658, at *11–*12 (D. Nev. Feb. 23, 2009) ("Services and Management Agreements" where parent provided functions to subsidiaries not indicative of alter ego status); *Everitt v. Dover Downs Ent'mt Inc.*, No. 98-cv-6116, 1999 WL 374163, at *6 (E.D. Pa. June 9, 1999) (it is "customary in a holding company structure" for "[c]ertain activities [to be] centralized").[2] Plaintiffs do not

[2] Plaintiffs' discussion of the medical loss ratio, Resp. 9 & n.3, is nonsensical. The medical loss ratio compares amounts spent on care to premiums. *See* 45 C.F.R. § 158.221. Administrative costs are not part of the formula. Achieving economic efficiency by sharing centralized functions with other entities in no way evades the medical loss ratio.

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suggest that these contracts are shams. *See Ranza*, 793 F.3d at 1074 ("proper documentation of transactions" between related companies supports finding that corporate formalities have been adequately observed).

Nor is it improper that Centene's 10-K (Ex. 6) calls the corporate family "we," or that a (third-party) website (Ex. 11) call Coordinated Care an "operating arm" of Centene. *See* Resp. 7, 12. Such terms are in fact "standard practices for a parent company." *Monje v. Spin Master Inc.*, No. 09-cv-1713, 2013 WL 2390625, at *7 (D. Ariz. May 30, 2013); *see also Doe v. Unocal Corp.*, 248 F.3d 915, 928 (9th Cir. 2001).

Perhaps most tellingly, Plaintiffs suggest that a capital contribution from Centene to Coordinated Care suggests an improper relationship. Resp. 11 (citing Ex. 9 at 26). But that is backwards; appropriately documented capital contributions "defeat[] an alter ego finding" because they prove that the parent "is not siphoning assets" or "trying to shield its assets by undercapitalizing its subsidiary." *Seiko Epson Corp. v. Print-Rite Holdings, Ltd.*, No. 01-cv-500, 2002 WL 32513403, at *18 (D. Or. Apr. 30, 2000). This fact betrays the fundamental weakness of Plaintiffs' arguments; for Plaintiffs, any fact that shows a connection between a parent and a subsidiary apparently proves an alter ego relationship, even

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if that fact shows the parent *supporting* the independent operation of the subsidiary.[3]

III. Jurisdictional Discovery Would Not Be Appropriate.

Plaintiffs make a perfunctory request for jurisdictional discovery and an evidentiary hearing, Resp. 14, but Centene respectfully submits that those steps are not justified in this case. Plaintiffs have not even attempted to show that respecting the corporate form in this case would promote fraud or injustice, and they have not controverted Defendants' evidence that Coordinated Care is adequately capitalized and fully financially able to conduct its business. Discovery would accordingly be "futile" because there is "no reasonable likelihood" that it would help Plaintiffs "prove that injustice would result" if Centene were dismissed. *Fru-Con Const. Corp. v. Sacramento Mun. Utility Dist.*, No. S-05-cv-583, 2007 WL 2384841, at *10 (E.D. Cal. Aug. 17, 2007). A "mere hunch that discovery might yield jurisdictionally relevant facts" is insufficient, *Puget Sound Surgical Center, P.S. v.*

[3] To the extent that Plaintiffs attempt to rely on a theory that "Coordinated Care and Superior are Centene's agents," Resp. 7, the Ninth Circuit has recognized that the "agency theory" of jurisdiction is likely invalid. *See Williams*, 851 F.3d at 1024. Even if it were viable, that theory would require far more than using the same language on two websites (Resp. 11–12). *Williams*, 851 F.3d at 1024–25.

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Aetna Life Ins. Co., No. 17-cv-1190, 2018 WL 1172992, at *7 (W.D. Wash. Mar. 6, 2018) (internal quotation omitted), and Plaintiffs have offered not even a hunch here.

IV. *Bristol-Myers Squibb* Applies To This Case.

Should this Court accept the jurisdictional arguments of Centene and Defendant Superior HealthPlan, Inc. (as it should), consideration of the effect of *Bristol-Myers Squibb* is unnecessary. Because Coordinated Care sells Ambetter policies only in Washington, there are no residents of other states that could have a viable claim. Otherwise, Centene maintains that *BMS* applies to this case. As to the mass action/class action distinction, *see* Resp. 15, this argument does not save Dr. Milman's claim from dismissal under *BMS*. And as to absent class members, this argument ignores the fact that Rule 23 is merely a claim-aggregation device; it does not expand courts' jurisdiction. *See Practice Mgmt. Supp. Servs., Inc. v. Cirque du Soleil, Inc.*, No. 14-cv-2032, 2018 WL 1255021, at *16 (N.D. Ill. Mar. 12, 2018) ("[A] defendant's due process interest should be the same in the class context."). As for the argument that the jurisdictional inquiry is different because Plaintiffs bring federal claims in federal court, Resp. 15–16), neither of those facts changes the result. Rule 4(k)(1)(A) renders the federal court/state court distinction irrelevant, and the presence of a federal claim only matters if the relevant statute

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provides for nationwide service of process. *See GN Trade, Inc. v. Siemens*, No. S-11-cv-994, 2011 WL 4591080, at *2 (E.D. Cal. Sept. 30, 2011).

V. The Complaint Fails To State Any Claim Against Centene.

For the same reasons that Plaintiffs have failed to demonstrate that Centene is Coordinated Care's alter ego for jurisdictional purposes, their Complaint also fails to state a claim against Centene under an alter ego theory. *See supra* pp. 3–7; *see also* Opening Mem. at 20.

A. Plaintiffs' ACA and Breach of Contract Claims Fail.

Plaintiffs base their breach of contract claim against Centene only on their alter-ego theory. *See* Resp. 24–25. They also do not suggest any other basis for bringing the ACA claim against Centene, which is not Ms. Harvey's "health plan." *See* Opening Mem. at 17. These two claims against Centene therefore fail.

B. Centene Did Not Violate Washington's Consumer Protection Act.

Plaintiffs suggest that Centene's responsibility for the (allegedly incorrect) information that Ms. Harvey found on www.wahealthfinder.org presents "a question of fact." Resp. 33. But wahealthfinder.org is the portal for the Washington health insurance exchange, and the Complaint itself identifies *Coordinated Care* as the party that sells Ambetter policies on that exchange, *see* Compl. ¶ 4, and the party from whom Ms. Harvey bought her plan, *see id.* ¶ 59.

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Ms. Harvey provides no basis for attributing statements on wahealthfinder.org to Centene; a Centene copyright on one document does not provide such a basis. *See Coffey v. Fort Wayne Pools, Inc.*, 24 F. Supp. 2d 671, 681 (N.D. Tex. 1998) (use of "promotional materials containing [defendant's] logo" did not demonstrate that wrongdoer acted under defendant's actual or apparent authority).

C. Centene Did Not Violate the Texas Deceptive Trade Practices Act.

The cases cited by Plaintiffs, Resp. 35, address whether a defendant is responsible for its *own* misstatements under the Texas DTPA. Neither of them explains why *Centene* would be liable for an alleged misrepresentation which the Complaint itself says *Superior* made. The Complaint states that the alleged misrepresentation of the in-network status of the Austin Diagnostic Clinic was on Superior's website, *see id.* ¶ 63, so Plaintiffs have failed to show that Centene is responsible for that representation.

CONCLUSION

For the foregoing reasons, the Complaint against Centene should be dismissed.

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Dated: May 29, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 29, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically generated a Notice of Electronic Filing (NEF) to all parties in the case who are registered users of the CM/ECF system. The NEF for the foregoing specifically identifies recipients of electronic notice.

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SECOND DECLARATION OF TRICIA DINKELMAN

I, Tricia Dinkelman, hereby testify and declare as follows:

1. I am over the age of 18 and competent to testify to and have personal knowledge of the matters contained herein. I submitted a declaration in support of Centene's Motion to Dismiss (ECF No. 16-2). I submit this second declaration in support of Centene's Reply in Support of its Motion to Dismiss. If called as a witness I could and would testify competently to the following:

2. I am employed by Centene Management Company, LLC as vice president of tax for Centene Corporation. Through my work in this position, I have gained personal knowledge of the matters contained herein relating to the relationship between Centene Corporation and its subsidiaries.

3. Centene Corporation is a holding company and has no employees.

4. Coordinated Care Corporation prepares its own financial statements. Excerpts from one such set of financial statements appear as Exhibit 9 to Plaintiffs' Response to Defendants' Motions to Dismiss (ECF No. 30) (hereinafter "Plaintiffs' Response" and "Plaintiffs' Exhibit[s]").

5. To the best of my knowledge, none of the exhibits submitted by Plaintiffs relate to Plaintiff Cynthia Harvey or Plaintiff Steven Milman or their care.

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6. With respect to Plaintiffs' Exhibits 1 and 2, the individuals whose names appear on the documents (Terri Soliz and Jodi Logue) are not employees of Centene Corporation. They both perform work for Coordinated Care Corporation, contracted through Centene Management Company, LLC, in Coordinated Care's Grievance and Appeals team in Tacoma, Washington.

7. As to Plaintiffs' Exhibit 4, the document bears the notation "Received by Centene" because requests for pre-authorization of treatment for all health plans within the Centene family of companies typically are received by a centralized intake channel and then routed to the relevant subsidiary for handling. Plaintiffs' Exhibit 4 does not relate in any way to Plaintiff Harvey, and was routed to Coordinated Care for handling.

8. As to Plaintiffs' Exhibit 5, Kim Burson was not a Centene Corporation employee. She performed work for Coordinated Care Corporation, contracted through Centene Management Company, LLC, in Coordinated Care's office in Tacoma, Washington.

9. Centene Management Company, LLC is a Wisconsin limited liability company headquartered in St. Louis, Missouri. It is a separate entity from Centene Corporation.

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10. At page 5 of Plaintiffs' Response, Plaintiffs write that the Washington State Office of the Insurance Commissioner "required both Centene and Coordinated to stop selling Ambetter policies in Washington." Plaintiffs' Response at 5 (citing Compl. ¶¶ 17–21). In fact, the Washington State Office of the Insurance Commissioner's order is directed to Coordinated Care, and makes no reference to Centene.

11. Attached as Dinkelman Exhibit 1 are excerpts from the health insurance contract between Coordinated Care Corporation and Plaintiff Harvey.

I declare under penalty of perjury that the foregoing is true and correct.

Dated May 29, 2018.

Tricia Dinkelman

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Exhibit 1

Excerpts from Health Insurance Contract Between Coordinated Care Corp and Plaintiff Harvey

ambetter. FROM coordinated care

2018 Evidence of Coverage

Ambetter.CoordinatedCareHealth.com

admission to a non-network Facility, or as soon thereafter as medically possible. If a Member is admitted to a Network Facility directly from the emergency room the emergency Cost Share is waived. However, coverage will be subject to any Inpatient Cost Sharing.

Urgent Care

In the Service Area, Urgent Care is covered at Network Hospitals and Urgent Care Centers, or Network Providers' offices. Urgent Care received at any Hospital emergency department is not covered unless Authorized in advance by us. Your free Preventive Care Benefits may not be used at an Urgent Care Center.

Outside our Service Area, if Authorized, Urgent Care is covered at any medical Facility. Members are responsible for Cost Share amounts and may be responsible for amounts above the Eligible Service Expense.

Hospital Based Providers

When receiving care at an in-network Ambetter Hospital, some Hospital-Based Providers may not be in-network. For example, you may receive services from anesthesiologists, radiologists, pathologists or Emergency Service Providers who are not contracted with Ambetter. While an in-network Hospital's emergency department is contracted with Ambetter, the Providers within the department may not be. As a result, these out-of-network Hospital-Based Providers may bill you for the difference between what Ambetter pays them and their total bill – this is known as Balance Billing. We encourage you to ask Providers if they participate with Ambetter before they treat you, so you know whether or not you may receive an additional bill for their services. If you receive a Balance Bill for Covered Services or for more information, please contact Member Services.

Transfer to Network Facility

If a Member is hospitalized in a non-network Facility, we reserve the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the Attending Physician, determines that the Member is Medically Stable for transfer. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

Women's Healthcare Direct Access Providers

Members may see a Network Provider, general and family practitioner, physician assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by us to provide Women's Healthcare Services directly, without Prior Authorization, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's Healthcare Services are covered as if the Member's Primary Care Provider had been consulted, subject to any applicable Cost Sharing, as set forth in the Schedule of Benefits. If the Member's women's healthcare Provider diagnoses a condition that requires a Prior Authorization to other specialists or hospitalization, the Member or the Member's chosen Provider must obtain Prior Authorization in accordance with applicable requirements.

Service Area

Coordinated Care operates in a limited Service Area. If you move from one county to another within the Service Area your premium may change. Please refer to the Premium section for more information. If you move from a county in the Service Area to a county not in the Service Area, you will no longer be eligible for coverage under this Contract and may be eligible for enrollment into another Qualified Health Plan during a Special Enrollment Period.

GRIEVANCE AND APPEAL PROCESS

We hope you will always be satisfied with us and our Providers. If you are not satisfied, please let us know. We offer the following processes if you are dissatisfied with the services you receive or a decision that we make:

1. Grievance Process – use this process to express a Complaint or dissatisfaction about customer service or the quality or availability of a health service.
2. Appeal Process – use this process to ask us to reconsider a decision (Adverse Benefit Determination) we made regarding your benefits or a claim.
3. External Review by an Independent Review Organization – this process is available for Members who are not satisfied with the final outcome of the Internal Appeal process.

Coordinated Care will assist you through the Grievance or Appeal process and will respond in a timely and thorough manner. We will ensure that the processes are accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that affect their ability to file a Grievance or an Appeal.

We will not retaliate against you or your Representative for filing a Grievance or an Appeal. We will not take, or threaten to take, any punitive action against a Provider acting on behalf or in support of any Member filing a Grievance or Appeal.

Representative means someone who represents you for the purpose of an Appeal. The Representative may be your treating Provider or can be another party, such as a family member or friend, as long as you or your legal guardian authorize, in writing, our disclosure of your protected health information for the purpose of an Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 14 years old. For Expedited Appeals only, a healthcare professional with knowledge of your medical condition is recognized as your Representative and can request an Expedited Appeal on your behalf without your consent. Even if you have previously designated a person as your Representative in a previous Appeal, an authorization designating that person as your Representative in a new Appeal will be required (but re-designation is not required for each Appeal level). If no authorization exists and is not received during the course of an Appeal, the determination and any personal information will only be disclosed to you and your treating Provider.

GRIEVANCE PROCESS

Coordinated Care strives to ensure that all interactions are positive and takes seriously any expression of dissatisfaction. Grievances can be related to health plan customer service or the quality or availability of a health service. Many Grievances can be resolved immediately on the phone. Coordinated Care will work to fully document, investigate and resolve any of your questions, concerns and Grievances.

How to File a Grievance

Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238). You can also write a letter and mail or fax your Grievance to Coordinated Care at 855-218-0588. A Grievance and Appeal Form may be found online at: https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html. Be sure to include:

1. Your first and last name.
2. Your Member ID number.
3. Your address and telephone number.

4. What you are unhappy with.
5. Any supporting documentation, (e.g., date and location of service, claim number, Provider name, etc.).
6. What you would like to have happen (desired outcome).

You have up to **180 calendar days** to file a Grievance. The 180 calendar days begins on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances Coordinator
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

The Grievance Coordinator will send you a letter within 48 hours of receiving your written Grievance or a Customer Service representative's summary. The letter will let you know that we have received your Grievance and the expected date of resolution. The letter also serves as both a written record of your Grievance as well as an acknowledgement.

If someone else is going to file a Grievance for you, we must have your written permission for that person to file a Grievance or Appeal on your behalf. You will need to obtain and fill out an Authorized Representative Form, and return it to us so that we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238) or by visiting our website at Ambetter.CoordinatedCareHealth.com.

If you have any proof or information that supports your Grievance, you may send it to us and we will add it to your case. You may supply this information to Coordinated Care by email, fax, in person, or other written method. You may also request to receive copies of any documentation that Coordinated Care used to make the decision about your care, Grievance, or Appeal. We may need to obtain additional information to review your request. If a signed Authorization to Release Information is not included with your Grievance, a form will be sent to you for your signature. If a signed authorization is not provided within 30 calendar days of the request, Coordinated Care may issue a decision on the Grievance without review of some or all of the information. When a signed request is received by your authorized Representative, appropriate proof of the designation must be provided.

You can expect a resolution and a written response for all Grievances within 30 calendar days of receipt of your Grievance. If Coordinated Care needs more than 30 days to resolve the Grievance, we will contact you to receive written approval for additional time.

If your Grievance is clinically urgent, it will be forwarded to the plan's Physician for review and resolved as quickly as possible, no later than seventy two (72) hours.

APPEAL PROCESS

You or your authorized Representative may file an Appeal when you wish us to reconsider a decision (Adverse Benefit Determination) we made regarding healthcare benefits, services or claims.

An Adverse Benefit Determination is a decision we made, based on review of information that was provided, to deny, reduce, modify or terminate payment, coverage, Authorization or provision of healthcare services or benefits, including the admission to or continued stay in a healthcare Facility.

If you have an Appeal about eligibility, your Appeal should be filed with the Washington Health Benefit

Exchange. Under federal law, the Exchange is responsible for all eligibility decisions. If your Appeal involves your eligibility or enrollment, please contact the Exchange at 1-855-923-4633 or visit www.wahbexchange.org.

How to File an Internal Appeal
Once you receive or learn of a decision or an Adverse Benefit Determination by us that you would like us to reconsider, you may file an Internal Appeal. Your Internal Appeal will be reviewed by people who were not involved in making the decision you are appealing. Your Internal Appeal may be reviewed as either a Standard Internal Appeal or as an Expedited Internal Appeal. If an immediate decision is required due to your health needs, an Expedited Appeal may be requested.

Appeals can be initiated through either written or verbal request. A Grievance and Appeal Form may be found online at: https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html. A written request may be faxed to 855-218-0589 or mailed to Coordinated Care at:

Grievance and Appeals Coordinator
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

To request an Appeal by phone, please call Member Services at:
1-877-687-1197

An acknowledgement letter will be sent within 72 hours of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within **180 calendar days** of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. **If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal and a review by an Independent Review Organization concurrently**. Please see Expedited Appeals later in this section for more information.

Internal Appeal Continuation of Care
If you are still receiving Covered Services that are under Appeal, the services may continue until a decision is made on the Internal Appeal. You should notify us if you are currently receiving services under Appeal, and that you would like to continue those services during the Appeal process. If the final decision in the Appeal process results in a denial, you may be responsible for the costs for services you received during the Appeal process.

Internal Appeal Review
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate the medical necessity decision of a final determination. You will be given a reasonable opportunity to provide written materials, including written testimony to support your Appeal. Coordinated Care will provide you, or your authorized Representative, with written notification of our decision:

1. For a pre-service non-expedited Internal Appeal, you will be notified within 14 calendar days of receipt of the Appeal,
2. For a post-service Appeal, you will be notified within 30 calendar days of receipt of the Appeal,
3. For Appeals involving an Experimental or Investigational treatment, you will be notified within 20 calendar days of receipt of the Appeal.

EXPEDITED INTERNAL APPEAL

Expedited Internal Appeal Qualifying Conditions
If your Provider feels that the matter being appealed is urgent due to health needs which cannot wait the standard resolution time, an Expedited Internal Appeal may be requested. Appeals regarding payment for services that have already been provided are not eligible for Expedited Appeals. An Expedited Internal Appeal may be requested if:

1. You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
2. The Appeal is regarding an issue related to admission, availability of care, continued stay or healthcare services received on an emergency basis where you have not been discharged.

Expedited Internal Appeal Submission
An Expedited Internal Appeal is requested in the same manner as a standard Internal Appeal. For an Expedited Internal Appeal your treating Provider may act as your authorized Representative without a signed written consent from you.

Expedited Internal Appeal Continuation of Care
If you are currently receiving Covered Services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously Authorized by Coordinated Care.

Expedited Internal Appeal Review
The content of the Expedited Internal Appeal request including all clinical care aspects involved will be fully investigated and documented. You or your authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the Expedited Internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty will evaluate the medical necessity decision of a final determination. The decision will be made as expeditiously as possible for an expedited review request, preferably within 24 hours, but in no case longer than 72 hours from the request for Appeal.

Appeal Determination Notification
The written notification of resolution of your Appeal will include the specific reasons for the decision. If the Appeal was not decided in your favor, you may request External Review by an Independent Review Organization (IRO). Information for pursuing an External Review will be included in the Appeal Determination letter.

EXTERNAL REVIEW

External Review Submission
If you are not satisfied with the final outcome of the Internal Appeal, you may request External Review of the decision by an Independent Review Organization (IRO). This includes, but is not limited to, decisions based on medical necessity, appropriateness, healthcare setting, level of care, or that the requested service or supply is not effective or otherwise unjustified under evidence-based medical criteria. For requests involving Experimental or Investigational treatments, the Independent Review Organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process. There is no cost to you for requesting External Review.

You or your authorized Representative may request External Review or Expedited External Review at the end of the Internal Appeal process. Instructions for submitting the request will be included with the Internal

Appeal Determination Notification we send. Expedited External Review can be submitted at the same time the Member submits a request for an Expedited Internal Appeal. You will be provided with at least five business days to submit additional information to the Independent Review Organization, in writing, that it must consider when conducting the External Review. Within one business day of receiving such additional information, the IRO will forward it to us.

Coordinated Care will work with you and the IRO. The decision made by an IRO is at no cost to you. We will provide the IRO with the denial and Appeal documentation. A written notice of the IRO's decision will be sent to you within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request.

External Review Continuation of Care
If you are still receiving Covered Services that are under External Review, the services may continue until a decision is made on the External Review. You should notify us if you are currently receiving services under External Review, and that you would like to continue those services during the External Review process. If the final decision in the External Review process results in a denial, you may be responsible for the costs for services you received during the External Review process.

Expedited External Review
If you disagree with the decision made in the Internal Expedited Appeal and you or your Representative reasonably believe that pre-authorization or concurrent care (Pre-Service) remains clinically urgent, you may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time you request an Expedited Appeal from Coordinated Care.

For Expedited External Reviews, the IRO's decision will be provided to you and us as expeditiously as possible after the decision, but no later than within 72 hours of the IRO's receipt of the request. If the initial notice is not in writing, the Independent Review Organization must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

External Review by an IRO is the final Appeal level. Coordinated Care is bound by the IRO's decision, except to the extent other remedies are available under state or federal law. External Review by an IRO is optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have with us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or toll free at (800) 562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at: https://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/.

Expedited External Review Continuation of Care
If you are currently receiving Covered Services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited External Review process if the Expedited External Review is filed timely and the service was previously Authorized by Coordinated Care.

Information
If you have any questions about the Grievance and Appeal process outlined here, you may contact our Member Services department at 1-877-687-1197 (TTY/ TDD 1-877-941-9238).