# CUSTOMER COMPLAINT HANDLING PROCEDURES

The Idaho AGC strives to provide the highest quality service to our customers at all times. We recognize that complaints may arise from time to time. We take your concerns very seriously and will do everything to find a resolution as quickly and efficiently as possible.

## HOW TO FILE A COMPLAINT

If you are not satisfied with any aspect of the Idaho AGC Health Plan, we ask that you first contact us with your concern so we can work together toward a resolution. Our contact information is below:

- By phone: (208) 344-9755
- By email: HealthPlanTeam@idahoagc.org
- In writing: Idaho AGC Health Plan, P.O. Box 7386, Boise, ID 83707

## WHAT TO INCLUDE WITH YOUR COMPLAINT

If you have documentation to support your complaint please provide it to us. Providing as much information and documentation as possible will assist in identifying the issue and ensure we include the appropriate individuals and/or companies that may be involved. This may include the Idaho AGC third-party administrators for medical, dental, vision, and life products.

Please provide the following documentation:

- Details of your complaint;
- All relevant documents related to your complaint;
- An explanation of why you disagree with the decision or handling, why are you dissatisfied with a product or service or why you are dissatisfied with the response you received;
- The resolution you are seeking and why you believe this resolution is appropriate.

## HOW WE HANDLE YOUR COMPLAINT

Step 1: We will work with all appropriate AGC staff and carrier(s), as applicable, to review your complaint. Our aim is to resolve the issue or concern as quickly as possible. You will receive a written acknowledgment within 3 business days of the receipt of your complaint. The letter will provide the contact details of the person who will be supporting you throughout the process.

Step 2: If we are unable to resolve the matter immediately, we will send you an acknowledgement letter within 15 business days of the date of receipt of your complaint. If the complaint pertains to a claim processed by a third party administer (TPA) or carrier, the AGC Health Plan will work in conjunction with the carrier or TPA to review the complaint based on the established review standard set by that TPA or carrier.

Step 3: A final response (or a written response informing you of the reasons for the delay in our final response and an estimated timeframe for response will be sent within 30 days after the date of the receipt of your complaint.

## QUESTIONS

If you have any questions about the Complaint Handling Policy or how to file a complaint, please contact the Health Plan Team.