10.3 Notification of Changes in Status

You shall notify Health Plan immediately in writing of any fact which may affect benefits under this Agreement, including but not limited to:

- eligibility for Medicare;
- coverage under another plan which may be subject to coordination of benefits; and
- eligibility for recovery from a third party of benefits which may be subject to subrogation.

11. COMPLAINT AND APPEAL PROCEDURE

11.1 Purpose

11.1.1 Health Plan recognizes that a member, physician, provider, or other person designated to act on behalf of a member may encounter an event in which performance under this Agreement does not meet expectations. It is important that such an event be brought to the attention of the Health Plan. The Health Plan is dedicated to addressing problems quickly, managing the delivery of Health Care Services effectively, and preventing future complaints or appeals. The Health Plan will not retaliate against You or Your Covered Dependents because You, Your Covered Dependents, Your Provider, or a person acting on Your behalf files a complaint or appeals a decision made by the Health Plan.

11.1.2 The Medical Director has overall responsibility for the coordination of the complaint and appeal procedure. For assistance with this procedure, individuals should contact the Health Plan office.

11.2 Complaints

11.2.1 Health Plan will send an acknowledgment letter of the receipt of oral or written Complaints from Complainants no later than five (5) business days after the date of the receipt of the Complaint. The acknowledgment letter will include a description of Health Plan's Complaint procedures and time frames. If the Complaint is received orally, Health Plan will also enclose a one-page Complaint form, which must be returned for prompt resolution of the Complaint.

11.2.2 Health Plan will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt of the written Complaint or one-page complaint form from the Complainant. However, investigation and resolution of Complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed one (1) business day from receipt of the Complaint.

11.2.3 Health Plan will investigate the Complaint and issue a response letter to the Complainant within thirty (30) days from receipt of the Complaint explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter will contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

11.3 Appeals

11.3.1 If the Complainant is not satisfied with Health Plan's resolution of the Complaint, the Complainant will be given the opportunity to appear before an appeal panel or address a written Appeal to an appeal panel.

11.3.2 Health Plan will send an acknowledgment letter of the receipt of oral or written appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will

include a description of Health Plan's Appeal procedures and time frames. If the Appeal is received orally, Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.3.3 Health Plan will appoint members to the complaint appeal panel, which shall advise the Health Plan on the resolution of the Complaint. The complaint appeal panel shall be composed of one Health Plan staff member, one Participating Provider, and one member. No member of the complaint appeal panel may have been previously involved in the disputed decision. The Participating Providers must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the Participating Provider serving on the appeal panel must be a specialist in the field of care to which the appeal relates. The members may not be an employee of Health Plan.

11.3.4 No later than five (5) business days before the scheduled meeting of the panel, unless the Complainant agrees otherwise, the Health Plan will provide to the Complainant or the Complainant's designated representative:

1) any documentation to be presented to the panel by Health Plan staff;
2) the specialization of any physicians or providers consulted during the investigation; and
3) the name and affiliation of each Health Plan representative on the panel.

11.3.5 The Complainant, or designated representative if the enrollee is a minor or disabled, is entitled to:

1) appear before the complaint appeal panel in person or by other appropriate means;
2) present alternative expert testimony; and
3) request the presence of and question any person responsible for making the prior determination that resulted in the Appeal.

11.3.6 Notice of the final decision of Health Plan on the Appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance.

11.3.7 Health Plan will complete the Appeals Process no later than the thirty (30) calendar days after the date of the receipt of the written request for Appeal or one-page appeal form from the Complainant.

11.3.8 Investigation and resolution of Appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one (1) business day after the Complainant's request for Appeal. Due to the ongoing emergency or continued hospital stay, and at the request of the Complainant, Health Plan shall provide, in lieu of a complaint appeal panel, a review by a Participating Provider who has not previously reviewed the case and is of the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review of the Appeal. The physician or provider reviewing the Appeal may interview the patient or the patient's designated representative and shall render a decision on the Appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three (3) days. Investigation and resolution of Appeals after emergency care has been provided shall be conducted in accordance with the standard Appeal process described above, including the right to a review by an appeal panel.

11.4 Appeal of Adverse Determinations

11.4.1 A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of the Health Plan's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, the return of which, while not required, will aid in the prompt resolution of the Appeal.

11.4.2 Health Plan will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the appeal; and provide written notification to the appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the oral or written Appeal or one-page Appeal form from the Complainant. If the Appeal is denied, the written notification shall include a clear and concise statement of:

1) the specific clinical basis for the Appeal denial;
2) the specialty of the physician or other health care provider making the denial; and
3) notice of the appealing party's right to seek review of the denial by an Independent Review Organization as provided in this Evidence of Coverage.

11.4.3 If the "Appeal of Adverse Determinations" is denied and within ten (10) business days the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the Appeal denial shall be reviewed by a Participating Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the Adverse Determination, and such specialty review will be completed within fifteen (15) business days of receipt of the request from the provider.

11.4.4 Health Plan will provide an expedited Appeal procedure for denial of emergency care, continued hospitalization, intravenous infusions, or prescription drugs. The procedure will include a review by a Participating Provider who has not previously reviewed the case and who is of the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review. The time in which such expedited Appeal will be completed will be based on the medical immediacy of the condition, procedure or treatment, but may in no event exceed one (1) business day from the date all information necessary to complete the Appeal is received.

11.4.5 Notwithstanding any provisions to the contrary, in a circumstance involving denial of emergency care, continued hospitalization, intravenous infusions, or prescription drugs, the enrollee is entitled to an immediate Appeal to an Independent Review Organization and is not required to comply with procedures for an "Appeal of Adverse Determination" described in this Evidence of Coverage.

11.5 Independent Review of Adverse Determinations

11.5.1 Health Plan will permit any party whose Appeal of an Adverse Determination is denied to seek review of that determination by an Independent Review Organization assigned to the appeal in accordance with Section 4202.001 et seq. of the Texas Insurance Code.

11.5.2 Health Plan will provide to the Independent Review Organization no later than the three (3) business days after the date of request by the Party a copy of:

1) any medical records of the enrollee that are relevant to the review;
2) any documents used by the plan in making the determination;
3) the written notification described in Section 11.4.2 of this document;
4) any documentation and written information submitted to the Health Plan in support of the Appeal; and
5) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the Appeal.

11.5.3 Health Plan will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee and the experimental or investigational nature of health care items and services for an enrollee.