

**CHILDREN'S HEALTH INSURANCE PROGRAM HEALTH BENEFIT PLAN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
NON-FEDERALLY QUALIFIED PLAN**

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN **Seton Health Plan** HEALTH BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE FEE AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM **Seton Health Plan** THROUGH THE CHIP PROGRAM.

Issued by

Seton Health Plan
7715 Chevy Chase Drive
Building IV, Suite 225
Austin, Texas 78752

1-512-324-3350
1-877-451-5601

In association with:

Children's Health Insurance Program
P.O. Box 149276
Austin, TX 78714-9983
1-800-647-6558

CHIP-EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Member Services Representative at 1-877-451-5601

Seton Health Plan

YOU may call Seton Health Plan's toll-free telephone number for information or to make a complaint at

1-877-451-5601

YOU may also write to (company) at Seton Health Plan
7715 Chevy Chase
Building IV, Suite 225
Austin, Texas 78752

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at

1-800-252-3439

YOU may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR fee or about a claim you should contact the **Seton Health Plan** first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con su representative al 1-877-451-5601

Usted puede llamar al numero de telefono gratis de Seton Health Plan's para informacion o para someter una queja' al

1-1-877-451-5601

Usted tambien puede escribir a Seton Health Plan
7715 Chevy Chase
Building IV, Suite 225
Austin, Texas 78752

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el **Seton Health Plan**. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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I. INTRODUCTION

A. YOUR CHILD'S Coverage under HEALTH PLAN

HEALTH PLAN provides benefits to YOUR CHILD for Covered Health Services under CHIP and determines whether particular health services are Covered Health Services, as described in **Section [XI], SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, below. If properly enrolled, YOUR CHILD is eligible for the benefits described in **Section [XI]**. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by HEALTH PLAN. YOU have a Contract with HEALTH PLAN regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP has determined that YOUR CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP also has determined YOUR CHILD'S eligibility for other benefits under the CHIP program.

II. DEFINITIONS

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

CHILD: Any child who CHIP has determined to be eligible for Coverage and who is enrolled under this Plan.

CHIP: The Children's Health Insurance Program which provides Coverage to each CHILD in accordance with an agreement between HEALTH PLAN and the Health and Human Services Commission of the State of Texas.

CLAIMS/CHIP ADMINISTRATOR: The contractor with the state that administers enrollment functions for CHIP health plans.

Controlled Substance: A toxic inhalant or a substance designated as a controlled substance in Subchapter C, Health and Safety Code.

Copayment: An additional charge to a Member for a service that is not fully prepaid by HEALTH PLAN.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in **Section [XI], SCHEDULE OF BENEFITS**,

EXCLUDED SERVICES AND COVERED HEALTH SERVICES, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Emergency and Emergency Condition: A medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the CHILD'S condition, sickness, or Injury is of such a nature that failure to get immediate care could result in:

- placing the CHILD'S health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant CHILD, serious jeopardy to the health of the fetus.

Emergency Services and Emergency Care: Health care services provided in an in-network or out-of-network Hospital emergency department or other comparable facility by in-network or out-of-network Physicians, Providers, or facility staff to evaluate and stabilize medical conditions. Emergency Services also include, but are not limited to any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Condition exists.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

WE will determine if this item 2. Is true based on:

- a. Published reports in authoritative medical literature; and
 - b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
 - a. It does not have FDA approval; or
 - b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
 - c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of

FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

- (i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or
 - (ii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.
 5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5, applies for protocols used by the CHILD'S Physician or Provider as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to CHILD issued by HEALTH PLAN providing Covered Health Services.

HEALTH PLAN: [Health Maintenance Organization's Name] otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a CHILD'S home by health care personnel, as prescribed by the responsible Physician or other authority designated by the HEALTH PLAN.

Hospital: A licensed acute care institution that primarily provides, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour per day nursing and Physician services.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Insurance Code Article 21.58C to conduct independent review of Adverse Determinations.

Injury or Accidental Injury: Accidental trauma or damage sustained by CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- ◆ reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause illness or infirmity of a CHILD, or endanger life;
- ◆ provided at appropriate facilities and at the appropriate levels of care for the treatment of CHILD'S medical conditions;
- ◆ consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- ◆ consistent with diagnoses of the conditions; and
- ◆ no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

Behavioral:

- ◆ reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve or maintain or to prevent deterioration of function resulting from the disorder;
- ◆ provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered CHILD, up to age 19, who is eligible for benefits under Title XXI of the Social Security Act and who is enrolled in the Texas CHIP program.

Out-of-Area: Any location outside HEALTH PLAN'S CHIP Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the state of Texas.

Primary Care Physician or Primary Care Provider (PCP) – A Physician, Physician Assistant, or Advanced Practice Nurse who is contracted with HEALTH PLAN to provide Covered Health Services to CHILD and who is responsible for providing initial and primary care, maintaining the continuity of care, and initiating referrals for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to or otherwise authorized to provide a health care service in this state. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, skilled nursing facility, or home health agency.

Serious Mental Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (hypomanic, manic, depressive, and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizo-affective disorders (bipolar or depressive);
6. pervasive developmental disorders;
7. obsessive-compulsive disorders; and
8. depression in childhood and adolescence.

Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties.

Specialist Physician: A participating Physician, other than a Primary Care Physician, under Contract with HEALTH PLAN to provide Covered Health Services upon referral by the Primary Care Physician or Primary Care Provider.

Substance Abuse or Chemical Dependency: The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Toxic Inhalant: A volatile chemical or abusable glue or aerosol paint as described in Subchapter C, Health and Safety Code.

Urgent Care – Health care for a condition which is not an Emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by his or her PCP or PCP designee to prevent serious deterioration in his or her condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: A review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to a CHILD.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: The family or guardian of the CHILD.

III. WHEN DOES AN ENROLLED CHILD BECOME COVERED?

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be subject to a waiting period before coverage actually begins. The waiting period for a child is determined by the date on which he/she is found eligible for CHIP, and extends for a duration of 3 months. If the child is found eligible for CHIP on or before the 15th day of a month, then the waiting period begins on the first day of that same month. If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month. Please refer to the table below for examples of how the waiting period affects the beginning of coverage. A child will remain covered for a term of 6 continuous months.

| Action | A | B |
|---|--------------------------------------|--------------------------------------|
| Eligibility Determination Date | January 1-15 | January 16-31 |
| 1 st day of Waiting Period | January 1 | February 1 |
| Family Completes Enrollment in CHIP Program | Before March CHIP Enrollment Cut-Off | Before April CHIP Enrollment Cut-Off |
| First Possible Date Coverage Can Begin | April 1 | May 1 |

IV. PAYING FOR YOUR CHILD'S COVERAGE

If you are required to pay a fee for your child's CHIP coverage, the fee is due with YOUR enrollment form.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility

Disenrollment may occur if YOUR CHILD loses CHIP eligibility. YOUR CHILD may lose CHIP eligibility for the following reasons:

1. "Aging-out" when CHILD turns nineteen;
2. Failure to re-enroll by the end of the 6-month coverage period;
3. Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
4. Death of a CHILD;
5. CHILD permanently moves out of the state;
6. CHILD is enrolled in Medicaid.
7. Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
8. Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
9. Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.

B. Disenrollment by HEALTH PLAN

YOUR CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons

1. Fraud or intentional material misrepresentation made by YOU after 15 days written notice;
2. Fraud in the use of services or facilities after 15 days written notice;
3. Misconduct that is detrimental to safe Plan operations and the delivery of services;
4. Failure of YOU or YOUR CHILD and a participating Physician or Provider to establish a satisfactory patient-physician/provider relationship so long as WE have, in good faith, provided YOU or YOUR CHILD the opportunity to select an alternative participating Physician or Provider. WE will notify YOU in writing 30 days in advance that WE consider the patient-physician/provider relationship to be unsatisfactory and will specify the changes that are necessary to avoid disenrollment. If such changes are not made, YOUR CHILD'S Coverage may be cancelled at the end of the 30 days;
5. CHILD no longer lives or resides in the Service Area.

We will not disenroll a CHILD based on a change in the CHILD'S health status or because of the amount of Medically Necessary Services that are used to treat the CHILD'S condition.

VI PREGNANT MEMBERS AND INFANTS

When WE receive notice from YOU, YOUR CHILD or YOUR CHILD'S Physician or Provider that a pregnancy has been diagnosed, WE will notify the HHSC Administrative Service Organization.

Depending on YOUR income and family size, the HHSC Administrative Service Organization may notify YOU and YOUR CHILD about her potential eligibility for Medicaid and of her ability to apply for Medicaid. In that situation, the Administrator will also provide appropriate resource information. A member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If YOUR CHILD is not eligible for Medicaid, the Administrator will extend YOUR CHILD'S eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the month of the baby's birth.

Newborns of CHIP members are automatically enrolled in the mother's health plan at birth. Eligibility for the newborn will continue until the coverage of the mother ends. At that time the eligibility of the mother and child will be redetermined.

VII. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU shall, at time of enrollment in the HEALTH PLAN, select YOUR CHILD'S Primary Care Physician or Primary Care Provider (PCP). A female Member may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in HEALTH PLAN'S published list of Physicians and Providers. YOU have the option to choose a Family Practice Physician with experience in treating children, a Pediatrician, or other qualified health care Provider as a PCP.

YOU shall look to the selected PCP and, if applicable, an OB/GYN, to direct and coordinate CHILD'S care, and shall accept recommended procedures and/or treatment.

B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU may request a change in YOUR CHILD'S Primary Care Physician or Primary Care Provider and a change in YOUR CHILD'S OB/GYN no more than four times a year. YOUR request must be made to HEALTH PLAN at least thirty (30) days prior to the requested effective date of the change.

C. Children with Chronic, Disabling or Life-threatening Illnesses

A CHILD who has a chronic, disabling or Life-threatening Illness may be eligible to receive services above and beyond those normally provided. If YOUR CHILD is identified as having special health care needs, YOUR CHILD will be eligible for Case Management Services for Children with Special Health Care Needs (CSHCN) through the Texas Department of State Health Services.

A CHILD who has a chronic, disabling, or Life-threatening Illness may apply to HEALTH PLAN'S medical director to use a non-primary Specialist Physician as a Primary Care Physician. The Specialist Physician must agree to the arrangement and agree to coordinate all of the CHILD'S health care needs.

D. Emergency Services

When YOUR CHILD is taken to a Hospital emergency department or to a comparable emergency facility, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care is required after the patient is stabilized, the treating Physician/Provider must contact HEALTH PLAN. HEALTH PLAN must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If HEALTH PLAN agrees to the care as proposed by the treating Physician/Provider, or if HEALTH PLAN fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care.

YOU should notify HEALTH PLAN within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

E. Out-of-Network Services

If Medically Necessary Services are not available to YOUR CHILD through network Physicians or Providers, HEALTH PLAN, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. HEALTH PLAN further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before HEALTH PLAN may deny a referral.

F. Continuity of Treatment

The contract between HEALTH PLAN and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently treating YOUR CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release HEALTH PLAN from its obligation to reimburse the Physician or Provider who is treating YOUR CHILD of special circumstance, such as a CHILD who has a Disability, acute condition, Life-threatening Illness, or is past the twenty-fourth week of pregnancy, at no less than the contract rate for YOUR CHILD'S care in exchange for continuity of ongoing treatment for YOUR CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

Special circumstance means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR CHILD be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still on HEALTH PLAN'S network. HEALTH PLAN shall reimburse the terminated Physician or Provider for YOUR CHILD'S ongoing treatment for ninety days from the effective date of the termination, or for nine months if YOUR CHILD has been diagnosed with a terminal Illness. For a CHILD who at the time of termination is past the twenty-fourth week of pregnancy, HEALTH PLAN shall reimburse the terminated Physician or Provider for treatment extending through delivery, immediate postpartum care, and follow-up checkup within six weeks of delivery.

G. Notice Of Claims

YOU should not have to pay any amount for Covered Health Services except for Copayments or Deductibles, if required, for certain services. If YOUR CHILD receives Emergency Services from out-of-network Physicians, Providers, or Hospitals, YOU may be required to pay for such care at the time it is received. In this instance, YOU should file a claim with the HEALTH PLAN within ninety (90) days from the date YOUR CHILD received Covered Health Services. If YOU file a claim after the ninety (90) day period, YOU are required to document why YOU could not submit the claim within the allotted time. Under no circumstances, will payment be made for claims submitted more than one year after a Covered Health Service was received.

H. Payment Of Claims

Payment of claims described in **Section VII.G. Notice of Claims**, will be processed no later than 30 days following receipt of the claim by the MCO.

I. COORDINATION OF BENEFITS

Your Child's coverage under CHIP is secondary when coordinating benefits with any group or individual health benefits coverage. This means that the coverage provided under CHIP will pay benefits for covered services that remain unpaid after any other group or individual health benefits have been paid.

J. Subrogation

HEALTH PLAN receives all rights of recovery acquired by YOU or YOUR CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by HEALTH PLAN, but only to the extent of such benefits. Upon receiving such benefits from the HEALTH PLAN, YOU and YOUR CHILD are considered to have assigned such rights of recovery to HEALTH PLAN and YOU agree to give HEALTH PLAN any reasonable help required to secure the recovery.]

VIII. HOW DO I MAKE A COMPLAINT?

A. Complaint Process

“Complaint” means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth business day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) calendar days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to the HEALTH PLAN

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE

- shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. WE shall send an acknowledgment letter to YOU not later the fifth day after the date of receipt of the request of the appeal.
 3. WE shall appoint members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees.
 4. Not later than the fifth business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
 - a. any documentation to be presented to the panel by OUR staff;
 - b. the specialization of any Physicians or Providers consulted during the investigation; and
 - c. the name and affiliation of each of OUR representatives on the panel.
 5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
 - a. appear in person before the Complaint appeal panel;
 - b. present alternative expert testimony; and
 - c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
 6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after YOUR request for appeal.

Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider may appeal the Adverse Determination orally or in writing.

Within 5 working days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider a one-page appeal form that must be completed and returned.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than 1 working day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 calendar days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.state.tx.us.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. additional information is needed;
2. an on-site review is necessary;
3. WE, the Physician or Provider, or YOU do not provide all documentation necessary to complete the investigation; or
4. other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against a CHILD because the CHILD or person acting on behalf of the CHILD has filed a Complaint against US or appealed a decision made by US.

2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Provider, because the Physician or Provider has, on behalf of a CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

IX. GENERAL PROVISIONS

A. Entire Agreement, Amendment

This Contract, and any attachments or amendments are the Entire Agreement between YOU and HEALTH PLAN. To be valid, any changes to this Contract must be approved by an officer of HEALTH PLAN and attached to this Contract.

B. Release and Confidentiality of Medical Records

HEALTH PLAN agrees to maintain and preserve the confidentiality of any and all medical records of YOUR CHILD or YOUR family. However, by enrolling in HEALTH PLAN, YOU authorize the release of information, as permitted by law, and access to any and all of medical records of YOUR CHILD for purposes reasonably related to the provision of services under this Contract, to HEALTH PLAN, its agents and employees, YOUR CHILD'S Primary Care Physician or Primary Care Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP and appropriate governmental agencies. HEALTH PLAN's privacy protections are described in more detail in its Notice of Privacy Practices. You may request a copy of the Notice of Privacy Practices by calling **1-877-451-5601**.

C. Clerical Error

Clerical error or delays in keeping records for YOUR and YOUR CHILD'S Contract with CHIP:

1. Will not deny Coverage that otherwise would have been granted; and
2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to the CHIP about YOUR CHILD are not accurate and they affect Coverage:

1. the true facts will be used by CHIP to decide whether Coverage is in force; and
2. any necessary and permitted adjustment by CHIP to the premium will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act and other applicable laws or regulations.

[CHIP EOC BENEFIT SCHEDULE A]
[CHIP EOC BENEFIT SCHEDULE B]
[CHIP EOC BENEFIT SCHEDULE C]
[CHIP EOC BENEFIT SCHEDULE D]
[CHIP EOC BENEFIT SCHEDULE E]