Questions, Complaints and Appeals Amendment

UnitedHealthcare of Texas, Inc.

Because this Amendment reflects changes in requirements of Federal and/or Texas law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Since this Amendment is part of a legal document (the group Contract), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Evidence of Coverage (EOC)* in *Section 9: Defined Terms.*

As described in this Amendment, the Contract is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Evidence of Coverage* with the provision below.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will send you a one-page complaint form that you must return to us for prompt resolution of the complaint.

We will promptly investigate each complaint. Within five business days, we will send a letter acknowledging the date we received your complaint. The total time for acknowledgement, investigation and resolution of the complaint, including the response letter, will not exceed 30 calendar days after we receive the written complaint or one-page complaint form.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case, and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Covered Person, Physician or provider. We will not retaliate for any reason including, cancellation of coverage or a provider contract, or refusal to renew coverage or a provider contract because the Covered Person, Physician, provider or person acting on behalf of the Covered Person has filed a complaint against the Contract or has appealed a decision.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require pre-authorization or benefit confirmation prior to receiving medical care.

Pre-Authorization

Pre-authorization, included within the pre-service request, is a request to us for proposed services that will result in one of the following:

- A pre-authorization;
- A confirmation of receipt of your request, when there are no clinical issues; or
- An Adverse Determination.

If you receive an Adverse Determination in response to your request for pre-authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, or a rescission of coverage determination, you can contact us orally or in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. The appeals process will be completed no later than 30 days after the written request is received.

Please note that our decision is based only on whether or not Benefits are available under the Contract for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Complaint Appeal Procedures

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision.

We will send an acknowledgment letter to the complainant within five business days after the date we receive the written request for an appeal.

We will appoint members to the complaint appeal panel, which advises us on the resolution of the appeal. The members of the complaint appeal panel cannot have been involved with your complaint in the past. The complaint appeal panel will include an equal number of our staff, Physicians or other providers with experience in the area of care to which your appeal relates, and enrollees.

No later than the fifth business day before the complaint appeal panel meets, we will provide to you or your designated representative with the following:

- Any documentation that will be presented by our staff to the complaint appeal panel.
- The specialization of any Physician or provider consulted during the investigation of your appeal.

- The name and affiliation of each of the members of our complaint appeal panel.

You, or your designated representative if you are a minor or disabled, have the right to:

- Appear in person before the complaint appeal panel at the site at which the Covered Person normally receives health care services, or at another site agreed to by the complainant.
- Address an appeal over the phone or in writing to the complaint appeal panel.
- Present alternative expert testimony.
- Request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your written appeal. Our final decision on the appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Investigation and resolution of appeals involving ongoing Emergencies or denials of continued hospitalization will be resolved in accordance with the medical immediacy of the case but no later than one business day after your request for appeal. At your request, we will provide, instead of a complaint appeal panel, a review by a Physician or provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the medical condition, procedure, or treatment under appeal. The Physician or provider reviewing the appeal may interview you or your designated representative and will make a decision on the appeal. Initial notice of the decision on the appeal including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision may be delivered orally to you but will be followed by a written notice of the determination within three days.

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 file a complaint with the *Texas Department of Insurance* at P.O. Box 149091, Austin, Texas 78714-9091. The *Department's* telephone number is 1-800-252-3439.

The *Commissioner of Insurance* will investigate a complaint against us to determine our compliance with insurance laws within 60 days after the *Department* receives your 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:

- Additional information is needed.
- An on-site review is necessary.
- We, the Physician or provider, or you do not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the control of the *Department* occur.

Adverse Determinations

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 Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms.*

Notice of Adverse Determinations

A utilization review agent will provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.

A utilization review agent will provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this Contract no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your provider of record receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your provider of record may appeal the Adverse Determination orally or in writing.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

We will complete the appeals process no later than the 30th calendar day after we receive your appeal.

If an appeal is upheld, within 10 working days of the appeal denial, the appeal may be reviewed by a Physician who is of the same specialty as the health care provider who would typically manage the medical condition, procedure, or treatment when the treating Physician certifies in writing there is good cause for the additional review. The specialty review will be completed within 15 working days from receipt of the request.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date

of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request

additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Contract, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
  - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.
  - Involves denial of prescription drugs or intravenous infusions for which you are receiving benefits.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO*'s final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Effective Date of this Amendment: June 30, 2018

UNITEDHEALTHCARE OF TEXAS, INC.

David Milich, President