FREEDOM LIFE INSURANCE COMPANY OF AMERICA

300 Burnett Street ◆ Suite 200 ◆ Fort Worth, Texas 76102 ◆ 1-800-387-9027

NOTICE OF INTERNAL GRIEVANCE PROCESS

Freedom Life Insurance Company of America ("Company, We, Us, Our") appreciate your business and want you to understand your rights about the Grievance Process under Maryland laws. References to "you" or "your" also apply to your covered dependents.

Definitions

"Adverse Decision" means a utilization review determination that a proposed or a delivered service which would otherwise be covered under your plan is or was not medically necessary or appropriate, resulting in reduced or non-payment of a benefit. Adverse decision does not include a decision concerning status as a member or decisions related to coverage.

"Compelling Reason" means a showing that the potential delay in the receipt of a health care service until after you, your representative or health care provider exhaust the internal grievance process and obtain a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, you remaining seriously mentally ill or using intoxicating substances with symptoms that cause you to be in danger to yourself or others, or you continuing to experience severe withdrawal symptom. You are considered to be in danger to yourself or others if you are unable to function in activities of daily living or care for self without imminent dangerous consequences.

"Complaint" means a protest filed with the Maryland Commissioner involving an adverse decision or Grievance Decision.

"Emergency Case" means a case involving an adverse decision for which an expedited review is required if the: (a) adverse decision is rendered for health care services that are proposed but have not been delivered; and (b) services are necessary to treat a condition or illness that, without immediate medical attention, would: (1) seriously jeopardize the life or health of the member or the member's ability to regain maximum function; (2) cause the member to be in danger to self or others; or (3) cause the member to continue using intoxicating substances in an imminently dangerous manner.

"Filing Date" means the earlier of:
(a) 5 days after date of mailing; or
(b) the date of receipt.

"Grievance" means a written protest regarding an adverse decision filed by you, your representative or health care provider on your behalf.

"Grievance Decision" means Our final determination after a review of a grievance regarding an adverse decision.

"Health Care Provider" means (1) an individual who is: (a) Licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession, and (b) A treating provider of a member; or (2) a hospital, as defined in §19-301 of the Annotated Code of Maryland.

“Member” (“you” or “your” herein) means a person entitled to health care benefits under a policy or certificate.

"Member's Representative" means an individual who has been authorized by the member to file a grievance or a complaint on the member's behalf.

“Utilization Review” means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.

General

You will receive a complete Explanation of Benefits documenting benefit decisions, for either requested pretreatment estimates or post-treatment claims. Your Explanation of Benefits will include clear and specific rationale for any denials or reductions of benefits. Adverse decisions are made by licensed physicians or dentists who review the submissions by treating physicians or dentists, respectively.

You, your representative or health care provider acting on your behalf can file a grievance concerning an adverse decision within 180 days after you receive the initial benefit decision.

Our grievance process in connection with utilization reviews will be delegated to a private review agent. You will be provided notices of Adverse or Grievance Decisions in a culturally and linguistically appropriate manner if the Affordable Care Act requires.

Responses and Timelines on Adverse and Grievance Decisions

Your grievance will be reviewed by a licensed physician who was not involved in the initial benefit decision, or a panel of appropriate health care service reviewers with at least one physician on the panel who is a licensed physician, who shall consult with a physician who is board certified or eligible in the same specialty as the service under review. When the health care service under review is a dental service, the adverse decision shall be made by a licensed dentist, or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel.

If within 5 working days of the filing date of a grievance, We cannot complete Our investigation without further information, We will notify you, your representative, or your health care provider about the information needed and offer to assist in gathering the necessary information without further delay.

We must render a final decision in writing on a grievance within:

(a) 45 working days after the filing date when the grievance involves a retrospective denial; or
(b) 30 working days after the filing date when the grievance involves a non-emergency prospective denial; unless you, your representative or health care provider agree in writing to an extension for a period of no longer than 30 working days.
(c) 1 day of the date a grievance is filed with Us for emergency care benefit decisions. Written adverse decision will be provided within 1 day of the oral communication.

With regard to the retrospective denial in (a) above, We may extend the 45-day period required for making a final Grievance Decision with the written consent of the member, the member's representative, or the health care provider who filed the grievance on behalf of the member.

For nonemergency cases, when We render an Adverse Decision, We will send, within 5 working days after the Adverse Decision has been made, a written notice to you, your representative and your health care provider acting on your behalf that:

(i) states in detail in clear, understandable language the specific factual bases for the Our decision;

(ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, will not use generalized terms such as “experimental procedure not covered,” “cosmetic procedure not covered,” “service included under another procedure,” or “not medically necessary”;

(iii) states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or

2. the designated employee or representative who has responsibility for the internal grievance process;

(iv) gives written details of Our internal grievance process and procedures; and

(v) includes the following information:

1. that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of Our Grievance Decision;

2. that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

3. the Commissioner's address, telephone number, and facsimile number;

4. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under Our internal grievance process; and

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

For nonemergency cases, when We render a Grievance Decision, We will send, within 5 working days after the Grievance Decision has been made, a written notice to you, your representative and your health care provider acting on your behalf that:

(i). states in detail in clear, understandable language the specific factual bases for Our decision;

(ii). references the specific criteria and standards, including interpretive guidelines, on which the Grievance Decision was based;

(iii). states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the Grievance Decision; or

2. the designated employee or representative of the carrier who has responsibility for the internal grievance process; and

(iv). includes the following information:

1. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's Grievance Decision;

2. the Commissioner's address, telephone number, and facsimile number;

3. a statement that the health advocacy unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; and

4. the address, telephone number, facsimile number, and electronic mail address of the health advocacy unit.

The final Grievance Decision will be communicated verbally to you, your representative or your health care provider acting on your behalf. We will reference the specific criteria and standards, including interpretive guidelines, on which the decision was based and will not use generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary".

Maryland Health Advocacy Unit

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You or your representative may contact:

Health Education and Advocacy Unit
Maryland Consumer Protection Division
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202
Toll-free: 877-261-8807
Local: 410-528-1840
FAX: 410-576-6571
TTY for Hearing Impaired: 1-800-576-6372
E-mail: consumer@oag.state.md.us

The Health Advocacy Unit is available to assist you in both mediating and filing a grievance under Our internal grievance process. The Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance and appeal process.

Filing Complaints with the Commissioner of Insurance in Maryland

You, your representative, or health care provider has a right to file a complaint with the Commissioner within 4 months after you receive Our Adverse or Grievance Decision. You or your representative will be required to authorize the release of any medical information that may be needed in the review in order to reach a decision on the complaint.

The internal grievance procedures should be exhausted prior to filing a complaint with the Commissioner unless:

(a) We waive this requirement,
(b) We have failed to comply with any of the steps in the internal grievance process, or
(c) You, your representative, or health care provider can provide sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to file with the Commissioner prior to completing the internal procedures.

For a non-emergency prospective denial, a complaint may be filed with the Commissioner if a Grievance Decision is not received on or before the 30th working day after the filing date of the grievance. For a retrospective denial, a complaint may be filed if a Grievance Decision is not received on or before the 45th working day after the filing date of the grievance. For emergency prospective denials, a complaint may be filed with the Commissioner of Insurance if a Grievance Decision is not received within 24 hours after filing the grievance.

If the Commissioner allows you, your representative or health care provider to submit additional information related to the complaint, you will have at least 5 working days to do so. If your complaint to the Commissioner involves a benefit decision based upon medical necessity, the Commissioner will select an independent review organization or medical expert to advise on the complaint. You always have the right to contact the Maryland Insurance Administration if you have a question or concern regarding your coverage under this contract. The Maryland Insurance Administration contact information is:

Maryland Insurance Administration's Grievance & Appeals Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202-2272
Consumer Hotline: 800-492-6116
Local: 410-468-2000
FAX: 410-468-2270
TTY for Hearing Impaired 1-800-735-2258

You also have the right to ask Us to review Adverse and Grievance Decisions involving your requests for service or your requests to have your claims paid. If you have any questions about the internal grievance procedures, please contact Freedom Life Insurance Company of America:

Title: Vice President of Consumer Affairs
Address: 300 Burnett Street, Suite 200
Fort Worth, Texas 76102
Toll-Free: 800-387-9027
Fax: 817-878-3440