WELLFLEET

Applicable to Maryland based schools/groups

Out-of-Network Provider Paid at IN-Network Level Guideline

Introduction	Wellfleet Group, LCC utilizes provider networks for Primary PPO savings, Transplant claims and precertification for several of our schools/groups.
Background	**A. Participating/In-Network Providers:** Although referrals are not required under our plans, members may request a standing referral to a specialist or Non-physician specialist if: 1. Member has a condition or disease that: a. Is life threatening, degenerative, chronic, or disabling; and b. Requires specialized medical care; and 2. The specialist or Non-physician specialist: a. Has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and b. Is a Preferred/In-Network Provider. Wellfleet shall provide a standing referral to a specialist or Non-physician specialist if the Member's Physician determines, in consultation with the specialist or Non-physician specialist, the Member needs continuing care from the specialist or Non-physician specialist. A standing referral shall be made in accordance with a written Treatment plan developed by the Member's Physician, the specialist or Non-physician specialist, and Member. The Treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the specialist or Non-physician specialist to communicate regularly with the Member's Physician regarding Your Treatment and health status. **B. Non Participating/Out-of-Network Providers:** Although referrals are not required, members may request a referral to a specialist or Non-physician specialist who is an Out-of-Network Provider if: 1. Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. 2. If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or

	Non-physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider. 3. For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider. The Member's request for a referral to a specialist or Non-physician specialist who is an Out-of-Network Provider shall be addressed in a timely manner that is: 1. appropriate for Your condition, and 2. within two (2) working days after receipt of the information necessary to make the determination. As used in this benefit: **Non-physician specialist** means a health care provider who: a. Is not a Physician; b. Is licensed or certified under the Health Occupations Article; and c. Is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider**; or** d. Who is licensed as a behavioral health program under Health-General Section §7.5–401. Steps for a member to request a non-panel (non-participating) provider specialist: To request a referral to a specialist or Non-physician specialist who is a Non-Preferred Provider, the Member should follow the below process: 1. Member contacts Wellfleet Customer Service phone number on the back of their Wellfleet Student Health insurance Plan (SHIP) identification card. 2. Wellfleet Customer Service Representative (CSR) will log the member call in the Wellfleet (LuminX) system noting the reason for the call. 3. Wellfleet CSR will provide the member with the name of the PPO network used on the member's plan. CSR will also review the member benefit plan and explain that the reimbursement may vary if an in or out of network provider is used for services. CSR will quote benefits based on the service being requested. If member would like to locate an in-network provider, the CSR will assist with looking at the networks online provider finder tool to provide the member with a list of in in-network providers. If the member decides to use an out-of-network provider, the CSR will log that information in the Wellfleet (LuminX) system to track that the member contacted Wellfleet to request that a non-panel provider will be utilized. 4. Member receives services from the out-of-network provider and Wellfleet processes the claim at the plan's out-of-network benefit level. Member cost share is calculated based on the out of network benefit level. If a member requests a referral to an out-of-network provider and the request is granted, we will follow the process above in item B and the claim will be reimbursed at the plans in-network level of benefit. Member may contact Wellfleet at the below address and phone number. Wellfleet Group, LLC

	P.O. Box 15369 Springfield, MA 01115 (877) 657-5030
Customer Service	At time of Intake call from member, Customer Service Representative (CSR) logs on to applicable network website to confirm there is no provider in the member's service area with the specific specialty to provide service to the member. Once confirmed, a note must be added to the member record in LuminX using log call code: "OO" (i.e., Out of network paid at in network rates request) to reflect no provider available in-service area with specific specialty, so claim will be processed at in-network level according to U&C.
Claim Process	Wellfleet will pay at the Preferred Allowance level for Treatment by a Non-Preferred Provider and will calculate the Insured Person's cost-sharing amount at the Preferred Provider level if: 1.there is no Preferred Provider in the service area available to treat the member for a specific Covered Injury or Covered Sickness; or 2.Wellfleet Group, LLC cannot provide the member access to a Preferred Provider to treat a specific Covered Injury or Covered Sickness without unreasonable travel or delay; or 3.there is an Emergency Medical Condition and the member cannot reasonably reach a Preferred Provider. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non-physician specialist who is a Non-Preferred Provider as if the service was provided by a Preferred Provider.
Grievance Process	If the member's request for a referral to a specialist or Non-physician specialist who is a Non-Preferred Provider is denied, the member has the right to file an internal grievance. The internal grievance process may be initiated by the member, or the member's authorized representative, or a health care provider acting on the members behalf, at least 180 days after receipt of the adverse decision. For questions regarding the grievance process, the member should contact a Customer Service Representative at: Wellfleet Group, LLC Attention: Appeals Unit Wellfleet Group, LLC P.O. Box 15369 Springfield, MA 01115 (877) 657-5030
Provider Team Process	Wellfleet's Provider team may reach out to the non-participating provider to request negotiation of the out-of-network services to reduce the out-of-pocket amount to the member.

For questions about this guideline, contact Laurie Beebe, Wellfleet Head of Provider & Network Management at lbeebe@wellfleetinsurance.com or 800-633-7867 ext. 244.

Commercial Carrier Process to Request a Referral to a Specialist or NonPhysician Specialist	
REVISED VERSION: 11/18/2022	
Wellfleet Insurance Company	
Consumer Contact Information	
Website	https://wellfleetstudent.com/
Phone Number	877-657-5030 (Wellfleet Customer Service Phone Number)
Requesting a Referral	
Steps to request a non-panel (non-participating) provider specialist	Wellfleet Insurance Company Student Health Insurance Plans (SHIP) typically do not require members to request a referral to a Specialist or NonPhysician Specialist. However, see below for the steps to see a non-panel provider specialist. Steps for a member to request a non-panel (non-participating) provider specialist: To request a referral to a specialist or Non-physician specialist who is a Non-Preferred Provider, the Member should follow the below process: 1. Member contacts Wellfleet Customer Service phone number on the back of their Wellfleet Student Health insurance Plan (SHIP) identification card. 2. Wellfleet Customer Service Representative (CSR) will log the member call in the Wellfleet (LuminX) system noting the reason for the call. 3. Wellfleet CSR will provide the member with the name of the PPO network used on the member's plan. CSR will also review the member benefit plan and explain that the reimbursement may vary if an in or out of network provider is used for services. CSR will quote benefits based on the service being requested. If member would like to locate an in-network provider, the CSR will assist with looking at the networks online provider finder tool to provide the member with a list of in in-network providers. If the member decides to use an out-of-network provider, the CSR will log that information in the Wellfleet (LuminX) system to track that the member contacted Wellfleet to request that a non-panel provider will be utilized. 4. Member receives services from the out-of-network provider and Wellfleet processes the claim at the plan's out-of-network benefit level. Member cost share is calculated based on the out of network benefit level. If a member requests a referral to an out-of-network provider and the request is granted, the claim will be reimbursed at the plans in-network level of benefit. Member may contact Wellfleet at the below address and phone number. Wellfleet Group, LLC P.O. Box 15369 Springfield, MA 01115 (877) 657-5030
Review full referral request procedures	**SECTION IV - STANDING REFERRAL** (the "live" link to where a member can locate their plans Certificate of Coverage which includes the below language is shown above in row 6; the URL is also included here: https://wellfleetstudent.com/ A.Participating/In-Network Providers: Although referrals are not required under our plans, members may request a standing referral to a specialist or Non-physician specialist if: 1.Member has a condition or disease that: a.Is life threatening, degenerative, chronic, or disabling; and b.Requires specialized medical care; and 2.The specialist or Non-physician specialist: a.Has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and b.Is a Preferred/In-Network Provider. We shall provide a standing referral to a specialist or Non-physician specialist if the Member's Physician determines, in consultation with the specialist or Non-physician specialist, the Member needs continuing care from the specialist or Non-physician specialist. A standing referral shall be made in accordance with a written Treatment plan developed by the Member's Physician, the specialist or Non-physician specialist, and Member. The Treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the specialist or Non-physician specialist to communicate regularly with the Member's Physician regarding Your Treatment and health status.

	As used in this benefit: Non-physician specialist means a health care provider who: a.Is not a Physician; b.Is licensed or certified under the Health Occupations Article; and c.Is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; or d.Who is licensed as a behavioral health program under General – Health Section §7.5–401. To request a referral to a specialist or Non-physician specialist who is a Non-Preferred Provision, the Member should contact a Customer Service Representative at: Wellfleet Group, LLC P.O. Box 15369 Springfield, MA 01115 (877) 657-5030
Carrier's timeline to grant or deny request	The Member's request for a referral to a specialist or Non-physician specialist who is an Out-of-Network Provider shall be addressed in a timely manner that is: 1.appropriate for Your condition, and 2.within two (2) working days after receipt of the information necessary to make the determination.
Grievance process to appeal denial of a request **How to file a grievance**	If the member's request for a referral to a specialist or Non-physician specialist who is a Non-Preferred Provider is denied, the member has the right to file an internal grievance. The internal grievance process may be initiated by the member, or the member's authorized representative, or a health care provider acting on the members behalf, at least 180 days after receipt of the adverse decision. For questions regarding the grievance process, the member should contact a Customer Service Representative at: Wellfleet Group, LLC Attention: Appeals Unit Wellfleet Group, LLC P.O. Box 15369 Springfield, MA 01115 (877) 657-5030 See the below process for "Full Grievance Process" including "How to File a Grievance"
Number of days for final grievance decisions	The Company's designee will 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, unless the Insured Person, the Insured Person's Authorized Representative of Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days; or (b)30 working days after the Filing Date when the Grievance involves a non-emergency prospective denial; unless the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days. (c)24 hours of the date a Grievance is filed with the Company's designee for an Emergency Case benefit decision. Written Adverse Decision will be provided within 24 hours of the oral communication.
Number of days/hours for emergency grievance decisions	24 hours of the date a Grievance is filed with the Company's designee for an Emergency Case benefit decision. Written Adverse Decision will be provided within 24 hours of the oral communication.

Review full grievance process	**SECTION IX – GRIEVANCE PROCEDURES** **NOTICE REQUIRED BY THE STATE OF MARYLAND:** **THERE IS HELP AVAILABLE TO THE INSURED PERSON IF THE INSURED PERSON WISHES TO DISPUTE THE DECISION OF THIS CERTIFICATE ABOUT PAYMENT FOR HEALTH CARE SERVICES.** The Insured Person may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202 , Mon-Fri 9 am- 4:30 pm at (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-261-8807, e-mail at heau@oag.state.md.us, or web address at www.oag.state.md.us. The Health Advocacy Unit can help the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider prepare a Grievance to file under the Company's Internal Grievance procedure. That unit can also attempt to mediate a resolution to the Insured Person's dispute. The Health Advocacy Unit is not available to represent or accompany the Insured Person during any proceeding of the Internal Grievance Process. Additionally, the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider may file a Complaint with the Maryland Insurance Administration, without having to first file a Grievance with the Policy, if: (1) the Policy has denied authorization for a Health Care service not yet provided to the Insured Person; and (2) the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider can show a Compelling Reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Insured Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Insured Person to be in danger to self or others, or the Insured Person continuing to experience severe withdrawal symptoms. I**NFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN policy, certificate,** enrollment material, or other evidence of coverage. **DEFINITIONS** As used herein: **Adverse Decision** means a Utilization Review determination made by a Private Review Agent that: 1.a proposed or delivered Health Care Service: a.which would otherwise be covered under the Policy is not or was not Medically Necessary, appropriate, or efficient; and b.may result in noncoverage of the Health Care Service. Adverse Decision does not include a decision concerning the Insured Person's status as an Insured Person under this Certificate.
	Authorized Representative means an individual who has been authorized by the Insured Person to file a Grievance or a complaint on the Insured Person's behalf. **Compelling Reaso**n means a Complaint that may be filed without first exhausting the Internal Grievance Process if the Complaint demonstrates a compelling reason to the satisfaction of the Maryland Commissioner of Insurance to do so, including a showing that the potential delay in receipt of a health care service until after the Insured Person or Health Care Provider exhausts the Internal Grievance Process and obtains 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, or the Insured Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Insured Person to be in danger to self or others if the Insured Person is 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 of Insurance involving an Adverse Decision or Grievance Decision concerning the Insured Person. **Emergency Case** means a case involving an Adverse Decision for which an expedited review is required. An expedited review of an Adverse Decision 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: (i) seriously jeopardize the life or health of the Insured Person or the Insured Person's ability to regain maximum function; or (ii) cause the Insured Person to be in danger to self or others; or cause the Insured Person to continue using intoxicating substances in an imminently dangerous manner. **Filing Dat**e: means the earlier of: (a) 5 days after the date of mailing; or (b) the date of receipt. **Grievance** means a protest filed by an Insured Person, an Insured Person's Authorized Representative or a Health Care Provider on behalf of an Insured Person, with the Company through the Company's Internal Grievance process regarding an Adverse Decision concerning the Insured Person. **Grievance Decisio**n means a final determination by the Private Review Agent that arises from a Grievance filed with the Private Review Agent under its Internal Grievance Process regarding an Adverse Decision concerning an Insured Person.
	Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article. **Health Care Provider** means: 1.an individual who is licensed under the Health Occupations Article to provide Health Care Services in the ordinary care of business or practice of a profession and is a treating provider of the Insured Person; or 2.a Hospital as defined by the laws of the state to operate as a health care facility. Internal Grievance Process: means a formal process, in accordance with Maryland statutes, established and maintained by the Company, its designee, or agent whereby the Insured Person, or the Insured Person's Authorized Representative, or a Health Care Provider acting on the Insured Person's behalf may contest an Adverse Decision rendered by the Company or its designee.

INTERNAL GRIEVANCE PROCESS

The Insured Person, or the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf, has the right to file an Internal Grievance when the Company's designee gives notice of an Adverse Decision regarding the Health Care Services furnished to the Insured Person. The Internal Grievance Process may be initiated by the Insured Person, or the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf at least 180 days of receipt of an Adverse Decision.

If the Insured Person receives Emergency Services from an Out-of-Network Provider, or the Insured Person incurs non- emergency Covered Medical Expenses from an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, and the Insured Person believes those services should have been paid at the In-Network level, the Insured Person has the right to file an Internal Grievance of that claim. If the Insured Person's Internal Grievance of a Surprise Billing claim is denied, the Insured Person has a right to file a Complaint with the Maryland Commissioner of Insurance as set out in the Complaints Procedures provision appearing in this Section.

If within 5 working days of the Filing Date of a Grievance, the Company's designee is unable to complete its investigation without further information, the Company's designee will:
(a) notify the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, that it cannot proceed with reviewing the Grievance unless additional information is provided; and
(b) assist the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf in gathering the necessary information without further delay.

The Internal Grievance Process will include adequate and reasonable procedures for review and resolution of appeals
concerning Adverse Determination, including procedures for reviewing appeals if the Insured Person's medical condition requires expedited review.

For non-Emergency Cases
I. When the Company's designee, renders an Adverse Decision, the Company's designee shall:

(A) document the Adverse Decision in writing after the Company's designee has provided oral communication of the decision to the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf; and
(B) send, within 5 working days after the Adverse Decision has been made, a written notice to the Insured Person, the Insured Person's Authorized Representative and the Health Care Provider acting on the Insured Person's behalf that:

a. states in detail in clear, understandable language the specific factual bases for the Company's designee's decision;
b. references the specific criteria and standards, including interpretive guidelines, on which the decision was based;
c. states the business address, and business telephone number to contact the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process. To contact the Company Representative responsible for Internal Grievance Process: Wellfleet Group, LLC, PO Box 15369, Springfield MA 01115-5369, telephone (800) 633-7867 or facsimile (413) 452-5329;
d. gives written details of the Company's designee's Internal Grievance Process and procedures; and
e. include the following information:
1. that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;
2. that the Complaint may be filed without first filing a Grievance if the Insured Person, the Insured Person's Authorized Representative or Health Care Provider filing a Grievance on behalf of the Insured Person can demonstrate a Compelling Reason to do so as determined by the Commissioner;
3. the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000, facsimile (410) 468-2020 or Toll-free 1-800-492-6116;
4. a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Grievance under the Company's designee's Internal Grievance Process; and
5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528- 1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us

II. When the Health Care Services under review is a mental health or substance misuse service, the Adverse Decision shall be made by a Physician, or a panel or other appropriate Health Care Services reviewers with at least one Physician, selected by the Private Review Agent who:
A. is board certified or eligible in the same specialty as the treatment under review; or
B. is actively practicing or has demonstrated expertise in the substance misuse or mental health service or treatment under review.
III. When the Health Care Services under review is a dental service, the Adverse Decision shall be made by a licensed dentist, or a panel of other appropriate Health Care Services reviewers with at least one licensed dentist on the panel.
IV. When the Health Care Services under review is for other than a mental health or substance misuse service, or dental service, the Adverse Decision shall be made by a Physician, or a panel of other appropriate Health Care Services reviewers with at least one Physician on the panel who is board certified or eligible in the same specialty as the treatment under review.
V. When the Grievance Decision involves a mental health or substance misuse service, the Grievance Decision shall be made based on the professional judgment of:
(A) who is a licensed Physician who is board certified or eligible in the same specialty as the treatment under review; or
(B) is actively practicing or has demonstrated expertise in the substance misuse or mental health service or treatment under review; or
(C) a panel of other appropriate Health Care Services reviewers with at least one Physician, selected by the Private Review Agent who is board certified or eligible in the same specialty as the treatment under review; or is actively practicing or has demonstrated expertise in the substance misuse or mental service or treatment under review.

VI.When the Grievance Decision involves a dental service, the Grievance Decision shall be made based on the professional judgment of a licensed dentist, or a panel of appropriate Health Care Services reviewers with at least one dentist on the panel who is a licensed dentist, who shall consult with a dentist who is board certified or eligible in the same specialty as the service under review.
VII.When the Grievance Decision involves services other than a mental health or substance misuse service or a dental service, the Grievance Decision shall be made based on the professional judgment of a Physician who is board certified or eligible in the same specialty as the treatment under review; or a panel of other appropriate Health Care Services reviewers with at least one Physician on the panel who is board certified or eligible in the same specialty as the treatment under review.

For Emergency Cases
An expedited review is deemed necessary when, in the opinion of the treating Health Care Provider, review under a standard time frame could, in the absence of immediate medical attention, result in any the following for the Insured Person:
(1)serious jeopardy of the life or health or the ability to regain maximum function;
(2)severe pain;
(3)serious impairment to such person's bodily functions;
(4)serious disfigurement of such person;
(5)being a danger to him or herself or others; or.
(6)such person using intoxicating substances in an imminently dangerous manner.

The Company's designee shall render a decision not later than 24 hours after receipt of the request for an expedited review of the Adverse Decision and within 1 day of orally providing the decision to the Insured Person, the Insured Person's Authorized Representative or the Insured Person's Health Care Provider, the Company's designee will send written notice to the Insured Person and, if the Grievance was filed on the Insured Person's behalf, to the Insured Person's Authorized Representative or Health Care Provider who filed the Grievance.

For an Emergency Case, a Complaint may be filed with the Commissioner if a Grievance Decision is not received within 24 hours after filing the Grievance pursuant to the Internal Grievance Process.

Responses and Timelines
I.Grievance Decisions . The Insured Person's Grievance will be reviewed by a Physician who was not involved in the initial Adverse Decision, or a panel or appropriate Health Care Services 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.

If within 5 working days of the Filing Date of a Grievance, the Company's designee is unable to complete its investigation without further information, the Company's designee will notify the Insured Person, the Insured Person's Authorized
Representative or Health Care Provider acting on the Insured Person's behalf, about the information needed and offer to assist in gathering the necessary information without further delay.

The Company's designee will 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, unless the Insured Person, the Insured Person's Authorized Representative of Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days; or
(b)30 working days after the Filing Date when the Grievance involves a non-emergency prospective denial; unless the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days.
(c)24 hours of the date a Grievance is filed with the Company's designee for an Emergency Case benefit decision. Written Adverse Decision will be provided within 24 hours of the oral communication.

The final Grievance Decision will be communicated orally to the Insured Person, the Insured Person's Authorized
Representative, or Health Care Provider acting on the Insured Person's behalf. Written notice of the final decision will be sent to the Insured Person, and if the Grievance was filed by the Insured Person's Authorized Representative or Health Care Provider, to either of them within 5 working days after the final decision has been made.

The written notice shall:
a.state in detail in clear, understandable language the specific factual bases for the Company's designee's decision;
b.state the name, business address, and business telephone number to contact the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process. To contact the Company Representative responsible for Internal Grievance Process: Wellfleet Group, LLC, PO Box 15369, Springfield MA 01115-5369, telephone (800) 633-7867 or facsimile (413) 452-5329;
c.include the following information:
1.that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;
2.the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000,
facsimile (410) 468-2020 or Toll-free 1-800-492-6116;
3.a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Complaint with the Commissioner; and
4.the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528-1840, facsimile (410) 576-6571 or
Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us.

The written decision 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 including under another procedure", or not Medically Necessary".

II.Coverage Appeal Decisions. Coverage denial appeals will be reviewed by claim analysts who were not involved in the original benefit decision. Claims analysts will have the expertise needed for the benefits in question. Review may be performed by escalating levels of management as necessary for each case.

The Company's designee will render a final decision in writing within 60 working days after the filing of an appeal. Within 30 calendar days after the appeal decision has been made, the Company's designee will send to the Insured Person, the Insured Person's Authorized Representative and/or Health Care Provider acting on the Insured Person's behalf, a written notice of the appeal decision. The Company's designee will reference the plan provision(s) on which the decision was based.