MARYLAND
Adverse Decision Notice – Addendum to Explanation of Benefits
Grievance and Appeal Rights

Your Explanation of Benefits provides information to you about our benefit decisions, for either requested prospective benefit estimates or post-treatment claims. Please refer to your Explanation of Benefits for clear and specific rationale for any adverse decisions, including denials or reductions of benefits.

Adverse Decisions, as defined below, are made by licensed dentists. For nonemergency cases, Ameritas will inform the member, representative, or health provider acting on the member's behalf of the adverse determination:

- Orally by telephone: or
- With the affirmative consent of the member, the member's representative, or the health provider acting on behalf of the member, by text, facsimile, e-mail, an online portal, or other expedited means; and
- This determination will be sent in writing to the member, authorized representative, and health care provider within five (5) working days after the adverse decision has been made.

Covered services for which benefits have been approved will later be denied only under the following circumstances:

- Information provided for review was fraudulent or intentionally misrepresentative,
- Critical information requested for and impacting the review was omitted, or
- The planned course of treatment that was approved was not substantially followed by the provider.

Ameritas will not utilize revised or modified specific standards to result in an adverse decision on services performed based on a prior approval of benefits.

This Notice provides important information about Grievance rights related to an Adverse Decision. This information may also be found in your policy or certificate and a copy is also sent to your authorized representative. References to "you" or "your" also apply to your covered dependents.

No medical necessity decisions are made for our vision benefits, therefore grievances are not applicable for vision. Appeals can be filed about benefit decisions based on the coverage described in your policy.

A. 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. Adverse Decisions are made by licensed dentists who review the submissions by treating dentists.

"Appeal" means a protest filed by you, your authorized representative or health care provider about a coverage decision affecting benefit payment.

"Appeal Decision" means a final determination by us after a review of an appeal regarding a coverage decision.

"Compelling Reason" means a showing that the potential delay in receipt of a health care service until after the member 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, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others, or the member continuing to experience severe withdrawal symptoms.

"Complaint" means a protest filed with the Maryland Commissioner involving an adverse decision or grievance decision, or a coverage decision.

"Coverage Decision" means our initial determination that results in non-coverage of a health care service. This includes our determination that you are not eligible for coverage under our plan or that your coverage has ended. Coverage decision includes non-payment of all or any part of a claim but does not include an adverse decision.

"Filing Date" means the earlier of:

(a) five (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 authorized representative, or a provider acting on your behalf

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

"Health Care Provider" means an individual or a hospital, as defined in §19-301 of the Health-General Article, 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.

"Insurer" means Ameritas Life Insurance Corp., also referred to as "we" or "us".

"Member" means a person entitled to health care benefits under a policy or certificate.

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

B. Grievance and Appeal Rights

Grievances concerning an adverse decision or Appeals regarding a coverage decision can be filed within 180 days after you receive the adverse decision or coverage decision.

The name of the individual responsible for our internal grievance and appeal procedures is the following:

Name:	Bruce Mieth
Address:	P.O. Box 82657
	Lincoln, Nebraska 68501-2657
Phone:	1- 877-897-4328 (Toll-Free)
Fax:	402-309-2579

The Maryland Insurance Commissioner and the Health Advocacy Unit are also available to help you, as described later in this Notice.

C. Adverse Determination Grievance Process

Your grievance will be reviewed by a licensed dentist who was not involved in the initial benefit decision, or a panel of appropriate health care service 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.

If within five (5) working days of the filing date of a grievance, we cannot complete our investigation without further information, we will notify you, your authorized 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 prospective denial; unless you, your authorized representative or health care provider agree in writing to an extension for a period of no longer than 30 working days.

The final grievance decision will be communicated verbally to you, your authorized representative or your health care provider acting on your behalf. Written notice of the final decision will be sent to you and, if the grievance was filed by your authorized representative or a health care provider, to either of them within five (5) working days after the final decision has been made.

D. Coverage Appeal Process

Your appeal will be reviewed by claim analysts who were not involved in the original benefit decision. Claims analysts will have expertise needed for the benefits in question. Reviews may be performed by escalating levels of management as necessary for each case.

We 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, we will send to you, your authorized representative and/or your health care provider acting on your behalf, a written notice of the appeal decision. We will reference the plan provision(s) on which the decision was based.

E. Health Advocacy Unit and Filing Complaints with Maryland Insurance Administration

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You may contact the Health Education and Advocacy Unit of Maryland's Consumer Protection Division at:

Health Education and Advocacy Unit
Maryland Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202-2021
Phone: 410-528-1840 or toll-free: 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

The Health Advocacy Unit can help you, your authorized representative, or health care provider prepare a grievance to file under our internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process.

Additionally, you, your authorized representative, or health care provider may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if:

1. the plan has denied authorization for a health care service not yet provided to you, and

2. you, your representative or your provider can show a compelling reason to file a complaint, including that a potential delay in receiving the health care service until after the member 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, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others or the member continuing to experience severe withdrawal symptoms.
OR
3. we waive the requirement for exhaustion of the internal grievance process OR
4. we have failed to comply with any of the steps in our internal process

INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN THE GRIEVANCE AND APPEAL PROCEDURES INCLUDED IN YOUR POLICY AND /OR CERTIFICATE

F. Filing Complaints with the Commissioner

Additionally, you, your authorized representative, or health care provider have a right to file a complaint with the Maryland Commissioner of Insurance within four (4) months after you receive our grievance or appeal decision. You or your authorized 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.

INFORMATION concerning these rights is also found in your policy or certificate.

For a prospective denial, a complaint may be filed 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.

If the Commissioner allows you, your authorized representative or health care provider to submit additional information related to the complaint, you will have at least five (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.

The Maryland Insurance Administration may be contacted as follows:

In Writing:	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

We want to be sure this information is helpful to you. We are sending it in a culturally and linguistically appropriate manner as described in the Affordable Care Act and 45 CFR 147.136 (e). We can provide interpreting services through our toll free Customer Service line shown in Section B. For Spanish only, you may call 1-800-487-5553 and speak directly to an employee who is proficient in the Spanish language. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print materials for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.