



Internal Grievance Procedures for Maryland 6.42

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Policy Manual: Clinical Appeals and Analysis Unit	Policy Section: Administrative Policies
Policy Owner Title: Senior Director, Medical Review and Appeals	
Effective Date: July 1, 1999 Last Review Date: March 10, 2022	

POLICY: Internal Grievance Process for Maryland (Fully Insured Business)

PURPOSE: This process has been designed with the following objectives:

- To comply with Maryland Code, Insurance, Section 15-10A and its implementing regulations,
- Section 503 of the Employee Retirement Income Security Act of 1974 (hereafter referred to as the "Act"), 29 U.S. 1133, 1135 which sets forth minimum requirements for employee benefit plan procedure pertaining to Claims for Benefits by Members.
- To address Adverse Decisions and Grievances based on medical necessity.
- To address Adverse Decisions and Grievances based upon a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a bona fide wellness program.
- To meet NCQA standards to the extent allowed by law.
- To improve customer satisfaction and continue quality customer service.

APPLIES TO: Grievances filed by members in fully insured benefit plans; those that do not include self-funded benefit plans and/or federal programs. This policy is applicable to CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., and First Care, Inc.

The Internal Appeal Process does not apply to:

- The nature or quality of medical care, and/or allegations of malpractice. The Plan reviews all quality-of-care issues through the Health Plan's Complaint Process.
- Coverage decisions and that Appeals Process. This information is provided under a separate policy.

The Health Benefit Plan (hereafter "Plan") ensures that members and providers are notified of their right to file a Grievance. The Plan Member/ Provider Services staff is available as a resource to assist the member or provider, acting on behalf of a member, in this process and ensures a timely response to their concerns.

These policies are intended to apply to all associates and contractors of CareFirst, Inc. and all affiliated, subsidiary, and related companies unless otherwise stated. Any exceptions to Company policy are noted in the Exceptions section.

DEFINITIONS:

- A "Grievance" is defined as a protest filed by a member (or an authorized representative of the member, which may include a health care provider on behalf of a member) with a carrier through the carrier's internal Grievance process regarding an Adverse Decision concerning the member.
- An "Adverse Benefit Determination" includes a denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including a denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental/investigational or not medically necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).
- An "Adverse Decision" is a utilization review determination by a Private Review Agent, a carrier, or a health care provider acting on behalf of a carrier that a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate or efficient and as a result, the requested service or payment for the service is therefore denied, reduced or terminated or a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a bona fide wellness program as defined in Maryland Code §15-509. An Adverse Decision does not include a decision concerning a subscriber's status as a member.
- A "Compelling Reason" means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member 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, 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.

- “Urgent Care” means any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or in the opinion of the physician with knowledge of the Member’s medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- “Complaint” means a protest filed with the Maryland Insurance Commissioner or the Office of Personnel Management in the case of a Multi-State Plan member, involving an Adverse Benefit Determination, Appeal Decision or a Grievance Decision concerning the member.
- “Filing date” means the earlier of five (5) days after the date of mailing or the date of receipt.

GENERAL:

I. Adverse Decision

When the Plan renders an Adverse Decision, the Plan shall document the Adverse Decision in writing after providing oral communication of the decision to the member or the member’s authorized representative and send within 5 working days after an Adverse Decision has been made, a written notice to the member, the member’s authorized representative and the health care provider acting on behalf of the member, in a culturally and linguistically appropriate manner as described in the Affordable Care Act (45 CFR § 147.136(e)). The contents of the written adverse decision notice are the same for emergency and non-emergency adverse decisions. The adverse decision notice shall contain the following information:

1. states in clear, understandable language the specific factual basis for the decision;
2. identifies the claim under review, including the date of service, the Health Care provider, the claim amount (if applicable);
3. the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be made available upon request;
4. includes the denial code and its corresponding meaning;

5. provides the specific reason or reasons for the Adverse Determination;
6. provides a description of any additional material or information necessary for the Member to perfect the claim and an explanation of why such material or information is necessary;
7. includes a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Benefit determination;
8. provides the name, business address, and business telephone number of the Medical Director who made the decision; whose names are:
 - a. Russell Lewis, M.D.
 - b. Robert H. Sadowski, M.D.
 - c. Deneen Bowlin, M.D.
 - d. Yvette Oquendo, M.D.
 - e. Jenny Moy, M.D.
 - f. Kevin Park, M.D.
 - g. Robert Ciaverelli, M.D.
 - h. Freeman Tichatonga Changamire, M.D.
 - i. Darius Cameron, M.D.
 - j. Anthony Massey, M.D.
 - k. Reed Wilson, M.D.
 - l. Cheryl Lerner, D.M.D
 - m. Barrett Bader, D.D.S.
 - n. Audley Diamond, D.D.S.
 - o. Claire L. Clarke, D.D.S
 - p. Karen Jacobs, D.D.S.
 - q. Jessica Lubek, D.D.S.
 - r. Sana Augustus, D.D.S.

The business address is:

1501 S. Clinton Street
Baltimore MD 21224

The business telephone number is:

410-528-7041

9. references the specific criteria and standards, including interpretive guidelines, on which the decision was based. Generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary" are not used;
10. if the Adverse Decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment

applying the terms of the plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

11. includes a description of the expedited review process and information regarding how to initiate an expedited grievance review;
12. gives written details of the Plan's internal Grievance process and procedures under the law.
13. The member or member's authorized representative or health care provider has a right to file a complaint with the Commissioner within 4 months after receipt of the Grievance decision.
14. A Complaint may be filed without first filing a Grievance if:
 - a. the Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint;
 - b. the Plan has failed to comply with any requirements of the internal grievance procedures;
 - c. the Plan has denied authorization for a health care service not yet provided to the Member;

A Complaint may be filed with the Maryland Insurance Administration without first filing a Grievance if the member or member's authorized representative or a health care provider filing a Grievance on behalf of the member can demonstrate a compelling reason to file a complaint, including that a delay in service 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.

Includes the statement that the following resources are available as specified by regulation:

The Maryland Insurance Administration may be contacted at:

Appeal and Grievance Unit
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270
TTY: 1-800-735-2258
Web: <http://www.insurance.maryland.gov>

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.

Correspondence should be addressed to:

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

The Health Education and Advocacy Unit can help you, your representative and your health care provider prepare a Grievance to file under the carrier's internal Grievance process. 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.

The letter will also include the following information:

INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN DOCUMENTATION SUCH AS THE POLICY, PLAN, CERTIFICATES, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

Preliminary Discussion Regarding an Adverse Decision

The member, or member's authorized representative, shall be instructed to contact the Plan Member Service area, or the Care Management Department, as appropriate, regarding an inquiry concerning an Adverse Decision. Often the inquiry regarding the Adverse Decision can be effectively addressed and resolved through preliminary discussion and administrative action prior to filing a Grievance. If the inquiry cannot be resolved by informal administrative action, the member, or member's authorized representative, can be assisted in filing a formal Grievance, if they wish to proceed in that manner. All verbal communication and written correspondence will be documented in a Call Tracking System. Written correspondence includes all documentation received or sent by the Plan, including (but not limited to) facsimile transmissions, interoffice mail, courier deliveries, and mail sent by the US Postal Service or other carrier and documentation received that is not a Grievance request, such as a question or general request for service assistance from the member or member's authorized representative.

Grievance Process: Non-Emergency

The member, or member's authorized representative or health care provider acting on behalf of the member, may submit a formal Grievance request in writing to the Plan. Correspondence should be addressed to:

Plan
c/o Mail Administrator

P.O. Box 14114
Lexington, KY 40512-4114
Phone 202-479-8000

Assistance in writing the formal request will be available from the Member Service area. A member, or the member's authorized representative may contact the dedicated Member Services Department by dialing the telephone number on the back of the membership card.

All hospital Grievances can be submitted directly to the Clinical Appeals and Analysis Unit, CareFirst BlueCross BlueShield, P.O. Box 17636, Baltimore, MD 21298. If a facility participates with CareFirst the member must be held harmless for denied services for medical necessity, per the participating institutional contract.

The written Grievance must be dated within 180 days from the date of receipt of the written Adverse Decision. The Plan Service Areas will prepare the Grievance packet for the Clinical Appeals Unit and will forward the packet to the Clinical Appeals Unit. The Grievance packet includes documentation of the substance of the Grievance and actions taken by the area that received the Grievance.

The person or persons appointed to review a Grievance involving medical necessity issues include(s) at least one practitioner who is board certified or eligible in the same specialty as the medical condition, procedure, or treatment under review who was not involved in the Adverse Decision. The Plan will seek assistance and opinion from the board-certified specialty panel/consultants as appropriate, who were not involved in the Adverse Decision. When the Grievance involves a dental/orthodontic service, in making the Grievance decision, the Plan will consult with a licensed dentist/orthodontist. If the grievance involves a mental health or substance abuse service a licensed physician who is board certified in the same treatment under review will be consulted.

A final Grievance decision will be rendered within 30 working days of the filing date of the Grievance for pre-service or pre-claim Grievances and within 45 working days for post service or post claim Grievances (an Adverse Decision regarding services which have already been rendered). The Health Plan will conduct a full investigation of the substance of the Grievance, including all aspects of clinical care involved. This investigation includes the collection of information pertinent to the individual clinical case, including one or more of the following:

1. All medical records such as progress notes, office records, laboratory reports, etc., as appropriate
2. Internal corporate or national medical policy, as appropriate.
3. Copies of or reference to available standards and/or criteria.
4. Claims payment history.
5. Call tracking history.
6. Contract.
7. Authorization history.
8. PCP/medical group records, as appropriate.
9. Health and Wellness Assessment Form, as appropriate.
10. Any information provided by the member and/or the member's authorized representative.

The Plan will provide a fair and full review that:

- a. Allows the member, the member's representative, or a health care provider filing a grievance on behalf of a member within 180 days following receipt of written notification of the adverse benefit determination to file an appeal or Grievance with the Plan.
- b. Takes into account all comments, documents, records, and other information submitted by the member relating to the claim, or an alternative standard or a waiver of a standard to satisfy the requirements of a bona fide wellness program, without regard to whether such information was submitted or considered in the initial benefit determination.
- c. Does not afford deference to the initial Adverse Decision and is conducted by an appropriate named physician of the Plan who is neither the individual who made the Adverse Decision, nor the subordinate of such individual. All medical necessity Grievances will be reviewed by a physician of the same specialty as the treatment under review, as appropriate.
- d. Allows an opportunity for the member or member's representative to submit written comments, documents or history related to the Grievance.
- e. Provides the member, the member's authorized representative or a health care provider who initiates a Grievance on behalf of the member with any new or additional evidence relied upon or generated by the Plan and the rationale used for a determination during the Grievance process sufficiently in advance of the due date of the response to an adverse determination, thereby allowing the member or the member's authorized representative or the health care provider an opportunity to respond.
- f. Provides a process whereby a CareFirst Medical Director makes all final Grievance decisions.
- g. Upon request, provides for the identification of experts whose advice was obtained on behalf of the Plan in connection with a member's Grievance, without regard to whether the advice was relied upon in making the Grievance determination; and
- h. The health care professional engaged for purposes of a consultation is an individual who is neither an individual who was consulted in connection with the Adverse Decision, nor the subordinate of any such individual.

There is a full investigation of the substance of the Grievance, including any clinical care involved.

The Plan Grievance decision is documented in writing after the Clinical Appeals Unit has provided oral communication of the decision to the member or the member's authorized

representative and the health care provider acting on behalf of the member, and the Grievance decision is then filed in the Grievance packet. Written notification of the Grievance decision is sent to the member within 5 working days after the Grievance decision has been made (not to exceed the total time-frame allowed for Grievance review. i.e. 30 working days pre-service or pre claim, 45 working days post service or post claim). The member, the member's authorized representative and a health care provider acting on behalf of the member shall be sent the Grievance decision in writing that complies with the requirements for a Notice of Adverse Decision, in a culturally and linguistically appropriate manner as described in the Affordable Care Act (45 CFR § 147.136(e)).

1. States in clear, understandable language the specific factual basis for the decision;
2. identifies the claim under review, including the date of service, the Health Care provider, the claim amount (if applicable);
3. the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be made available upon request;
4. includes the denial code and its corresponding meaning;
5. provides the specific reason or reasons for the Grievance determination;
6. references the specific criteria and standards, including interpretive guidelines, on which the decision was based. Generalized terms such as "cosmetic procedure not covered," or "not medically necessary" are not used;
7. includes a statement that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all document, records and other information relevant to the Member's claim for benefits;
8. if the Adverse Decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
9. Provides the name, business address, and business telephone number of the Medical Director who made the decision; whose names are:
 - a. Russell Lewis, M.D.
 - b. Robert H. Sadowski, M.D.
 - c. Deneen Bowlin, M.D.
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 - e. Jenny Moy, M.D.
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 - g. Robert Ciaverelli, M.D.
 - h. Freeman Tichatonga Changamire, M.D.
 - i. Darius Cameron, M.D.

- j. Anthony Massey, M.D.
- k. Reed Wilson, M.D.
- l. Cheryl Lerner, D.M.D
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- o. Claire L. Clarke, D.D.S
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- q. Jessica Lubek, D.D.S.
- r. Sana Augustus, D.D.S.

The business address is:
1501 S. Clinton Street
Baltimore MD 21224

The business telephone number is:
410-528-7041

10. Provides information to the member, the member's representative or the health care provider acting on behalf of the member concerning the right to file a complaint with the Commissioner within 4 months after receipt of the Grievance decision from the Plan written as:

You also have the right to file a complaint with the Insurance Commissioner within 4 months after receipt of the Grievance decision by contacting the Commissioner.

Complaints should be addressed to:

Appeals and Grievances Unit
Maryland Insurance Administration

200 Saint Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 1-800-492-6116 (toll free)
Fax: 410-468-2270
TTY: 1-800-735-2258
Web: <http://www.insurance.maryland.gov>

11. The following resources are also available by regulation and written as:

The Health Advocacy Unit is available to assist you, your representative or your health care provider if you wish to dispute the decision of the Plan about payment for health care services. The Health Advocacy Unit is also available to assist you, your representative or your health care provider in filing a complaint with the Commissioner.

Correspondence should be addressed to:

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

12. The letter will also include the following information:

INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN DOCUMENTATION SUCH AS THE POLICY, PLAN, CERTIFICATES, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

13. In addition, the letter may include the following statements:

When filing a complaint with the Commissioner, the member or the member's authorized representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

And the statement:

You or your authorized representative may pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Information is also available at www.askebsa.dol.gov.

And the statement:

You or your authorized representative may request access to or copies of all documents, records or other information relevant to this Grievance decision, free of charge, including copies of the benefit provision, guideline or protocol or other similar criterion on which the Grievance decision was based. To make a request, call the number for Member Services on your membership card.

Note: If a facility participates with CareFirst the member must be held harmless for denied services per the institutional contract; therefore, ERISA/DOL Regulations will not apply.

Request for Additional Information

If within 5 working days after the member, the member's authorized representative or a health care provider on behalf of the member files a Grievance with the Plan, the Plan does not have sufficient information to complete its internal Grievance process, the Plan shall notify the member, the member's authorized representative or a health care provider on behalf of the

member that the process cannot continue unless additional information is received. The Plan will assist the member or provider in gathering this information.

Grievance Process: Emergency

In addition to the above, the member, healthcare provider or member's authorized representative may request an emergency Grievance. A licensed nurse will make the determination that the Grievance asserts an emergency case, based on review of the written or verbal medical information available to determine if the case involves prospective care; and the health services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the member or the member's ability to regain maximum function, (ii) cause the member to be in danger to self or others; or (iii) cause the member to continue using substances in an imminently dangerous manner.

The decision for an emergency Grievance shall be made with consultation of a board certified or eligible physician opinion in the same specialty of the treatment under review and will be based on the available medical information provided by the attending physician and/or facility and member. The physician making the emergency Grievance decision will not be the same physician as in the initial adverse decision. The member, or member's authorized representative, and the health care provider on behalf of the member will be contacted by telephone or facsimile, (depending on availability) if additional information is requested. As part of this communication, the member, member's authorized representative and the health care provider will be advised that the Plan is available to assist in gathering this information. * The Plan will assist the member or provider in gathering this information. For an emergency Grievance a complaint may be filed with the Commissioner or the Office of Personnel Management if a Grievance decision is not received within 24 hours after filing the emergency Grievance. The member/provider may file a complaint with the Commissioner or the Office of Personnel Management without first filing a Grievance with the Plan if there is a compelling reason to do so.

An emergency Grievance decision shall be made within 24 hours of the time that the Grievance is filed with the Plan. Within one day after a decision has been orally communicated to the member or member's authorized representative, or the member's treating physician, the Plan shall send notice in writing of any Grievance decision to the member, the member's authorized representative and the health care provider on behalf of the member the information as described in the non-emergency Grievance process as written above.

Contact between the Plan and the MIA/HAU

There is a dedicated contact in the Clinical Appeals Unit for the Maryland Insurance Administration, the Health Advocacy Unit inquiries/complaints. A Supervisor Nurse Analyst is responsible for acting as the regulatory liaison. In addition, there will be communication to the MIA/HAU verbally and/or in writing, as necessary, to assure that the Clinical Appeals Unit is providing all of the necessary and complete information as appropriate.

If the MIA overturns the Plan's Grievance determination, this decision will be forwarded to the Clinical Appeals Unit Manager for review and appropriate action.

- a. When more information is needed for a Grievance Decision: The Plan will send notice within 5 working days that it cannot proceed with its review unless the additional information is provided. The Plan will assist in gathering the necessary information. The response deadlines described above may be extended one time by The Plan for up to 15 days, provided that The Plan both:

- b. Determines that such an extension is necessary due to matters beyond the control of The Plan; and
- c. Notifies the member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which The Plan expects to render a decision.

If such an extension is necessary due to a failure of the member to submit the information necessary to decide the Grievance, the notice of extension shall specifically describe the required information, and the member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the event that a period of time is extended due to a member's failure to submit necessary information, the period for responding to an Appeal shall be tolled from the date on which the notification of the extension is sent to the member until the date on which the member responds to the request for additional information.

The member must agree to this extension in writing. The member will be asked to sign a consent form.

*If the member fails to provide sufficient information, the Plan will notify the member as soon as possible, but not later than 24 hours after receipt of the request for Grievance. The member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the member of the Grievance determination as soon as possible, but in no case later than 48 hours after the earlier of:

- a. The Plan's receipt of the specified information; or
- b. The end of the period afforded the member to provide the specified additional information.

For emergency Grievances, all emergency Grievance decisions must be made within 24 hours of the date a Grievance is filed, regardless of the information available at the time of Grievance and Grievance decision.

Exhaustion of Internal Claims and Appeal Process

If the Plan that fails to adhere to the minimum requirements for procedures relating to Claims for Benefits by Members or Section 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal appeals and grievance processes.

Accordingly, the Member may initiate an external review as applicable. The Member is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the Claim for Benefits.

If a Member chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

POLICY RULES:

N/A

RESPONSIBILITY:

Clinical Appeals and Analysis Unit

VIOLATIONS:

Violation of this policy may result in fines incurred to the Plan by Regulatory and Federal Agencies or loss of accreditation by governing bodies.

EXCEPTIONS: N/A

LEGAL REFERENCE OR CITATION:

See Within