DELTA DENTAL OF ILLINOIS (DDIL)
CLAIMS APPEAL PROCEDURES

Prior Approval of Benefits: This group dental plan *does not require* prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, DDIL shall notify the Subscriber of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. DDIL will notify the treating Dentist as well by issuing an Explanation of Payment. If an extension is necessary, DDIL shall notify the Subscriber and the treating Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the Subscriber or the treating Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;
- A description of DDIL's appeal process and the time limits applicable to the process, including a statement of the Subscriber's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA following an adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Request for Appeal of Adverse Benefit Determination: If the Subscriber disagrees with DDIL's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific plan provisions upon which the determination is based;
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request;
- A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Special Provisions Applicable to DeltaCare Dental HMO Programs

Except as provided below, claims and appeals filed under DeltaCare programs shall be handled in accordance with the procedures set forth above in the sections entitled *Notice of Adverse Benefit Determination* and *Request for Appeal of Adverse Benefit Determination*.

Pre-Service Claims (Specialty Referrals): In the case of a request for specialty referral requiring pre-authorization by the DeltaCare Administrator, the DeltaCare Administrator shall notify the referring Panel Dentist and the Subscriber of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the circumstances, but not later than 15 days after the referral request is filed. This period may be extended one time by the plan for up to 15 days if necessary due to matters beyond the control of the plan. If an extension is necessary, the DeltaCare Administrator shall notify the Panel Dentist and the Subscriber within the original 15-day period, of the circumstances requiring the extension and the date by which the plan expects to render a

decision. If an extension is needed because the Panel Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Panel Dentist shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the event a specialty referral request requiring pre-authorization is denied, the Panel Dentist or the Subscriber may appeal this determination in writing to the DeltaCare Administrator within 180 days following receipt of the denial notice. The DeltaCare Administrator shall notify the claimant in writing of its determination on review within 30 days of receipt of the request for review.

Urgent Care Claims (Emergency Referrals): In the case of a request for emergency referral, the DeltaCare Administrator shall notify the Panel Dentist and the Subscriber of its benefit determination, whether adverse or not, as soon as possible, but not later than 72 hours after receipt of the referral request. The notice shall include a description of the expedited review and appeal process applicable to urgent care claims. If the Panel Dentist fails to provide sufficient information to decide the claim, DeltaCare shall notify the Panel Dentist and the Subscriber of the specific information required to make a determination on the claim as soon as possible, but not later than 24 hours after receipt of the claim. The Panel Dentist 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 DeltaCare Administrator then shall notify the Panel Dentist and the Subscriber of its determination as soon as possible, but not 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 Panel Dentist to provide the additional information.

If an expedited review of a claim denial involving urgent care is necessary, a request for such review may be submitted orally or in writing by the Subscriber or by the Panel Dentist by telephone, facsimile or other similarly expeditious method. The DeltaCare Administrator shall notify the claimant of the determination on review as soon as possible, but not later than 72 hours after receipt of the request for review.