



ALTUS DENTAL INSURANCE COMPANY, INC. CONSUMER RIGHTS AND APPEALS

Claims Procedures

If you have a question about the payment or denial of a claim, call Customer Service toll free at 1-877-223-0588. You have a right to request a full and fair review of your claim. **To be eligible for payment, all claims must be received within 180 days of the date you receive services and must be in accordance with Altus Dental's utilization review guidelines.** All services must be complete to qualify for benefits (e.g., permanent crowns cemented, bridge or denture inserted).

Pre-treatment Estimates

A pre-treatment estimate is a claim that is filed prior to dental care being received. Filing a pre-treatment estimate with Altus Dental before you receive services allows us to review the treatment plan and let you know, in advance, how much we will cover. Pre-treatment estimates are recommended, but not required, for services costing \$300 or more. In other words, you do not need to receive an approval of the benefit in advance of obtaining dental care in order for the claim to be considered for payment.

We will notify you in writing or electronically of an initial determination on a pre-treatment estimate within 30 business days of receipt of all information necessary to complete the review. In accordance with Rhode Island state law, for RI residents and/or where services are intended to be performed in RI, we will notify you of an initial adverse determination on a pre-treatment estimate for non-urgent and non-emergency cases within 15 business days of receipt of all information necessary to complete the review and prior to the proposed date of service. For urgent or emergency cases, notification of an adverse determination on a pre-treatment estimate is mailed or otherwise communicated within 72 hours of receipt of all information necessary to complete the review and prior to the proposed date of service.

If the service is denied, the notice will explain the reason(s) for the denial and will include the procedures for filing an appeal. Once an adverse determination is made, you have 180 days from receipt of our notice within which to file an appeal.

Post-service Claims

A post-service claim is a claim that is filed after dental care has been received. We will notify you in writing or electronically of an initial adverse determination on a post-service claim within 30 calendar days of receipt of the claim. If we cannot process a post-service claim because it is missing information, we will notify you within 30 days of what additional information is needed. A participating dentist may not charge the patient for any amount that has not been paid as a result of the dentist's failure to provide the necessary information to process the claim. For claims involving emergency medical conditions, refer to the **Expedited Reviews** section below.

In the event that we fail to provide written notice or payment to you or your dentist within 45 days after receipt of a complete claim with all necessary supporting documentation, you shall be entitled to interest on the amount of the unpaid claim at a rate of 1.5 percent per month (not to exceed 18 percent per year) from the 45th day after our receipt of such complete claim.

If the service is denied, the notice will explain the reason(s) for the denial and will include the procedures for filing an appeal. Once an adverse determination is made, you have 180 days from receipt of our notice within which to file an appeal.

For both **Pre-Treatment Estimates** and **Post-Service Claims**, under Rhode Island law, for a Rhode Island resident or for services performed by a Rhode Island dentist, your dentist has the right to request a two-way direct communication with our dental consultant prior to us making an initial adverse determination by calling Customer Service at (401) 752-6100.

To Appeal a Claim Determination

If your claim is denied, in whole or in part, you may request a review of the denied claim by sending us a written request for appeal within 180 days from the date you receive our original notice. Processing policy messages on your Explanation of Benefits or Pre-Treatment Estimate notice explain the reason(s) for the denial, refer to any plan provisions on which the decision was based, and refer to a guideline, protocol or criteria we used to make the adverse decision (if applicable). You also have the right, on request and free of charge, to reasonable access to, and copies of, all documents relevant to your claim. Furthermore, on a written request, and free of charge, Altus Dental will provide you with a copy of any internal rule, guideline or protocol, and/or, if applicable, an explanation of the scientific or clinical judgment we used to decide your claim.

Our appeals process allows for one level of internal appeal or, in cases where an adverse determination was based on a failure to meet our utilization review guidelines, two levels of internal appeal and an opportunity for external review. You also have the right to bring a civil action under Section 502(a) of the ERISA Act once you have exhausted the applicable internal appeals process, except in cases where you are a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

To initiate the first level of internal appeal, you must do so in writing within 180 calendar days of receipt of the original denial notice. You should write to the attention of **Appeals, Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI, 02901-1557**. Your appeal should ask for reconsideration and include a copy of the Explanation of Benefits or Pre-Treatment Estimate notice, the patient's name, the subscriber identification number, the reason why you believe the claim was wrongly denied, and any other information you believe supports your claim (e.g., x-rays, narrative, charting, photos, treatment records, etc.). In cases where an adverse determination was based on a failure to meet our utilization review guidelines, a dental consultant will review your appeal.

We will provide you with a written or electronic resolution of the appeal within 30 calendar days of our receipt of the appeal. In accordance with Rhode Island state law, for RI residents and/or where services are to be performed in RI, we will provide you with a notice within 15 business days after we received the appeal. For appeals involving emergency medical conditions, refer to the **Expedited Reviews** section below. If an adverse determination is issued as a result of the first internal appeal, you then have the opportunity to initiate a second internal appeal if the decision was based on a failure to meet our utilization review guidelines; otherwise, the internal appeals process is concluded. Following the conclusion of the internal appeals process, you have the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where you are a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

To initiate a second internal appeal, you must do so in writing within 180 calendar days of receipt of the notice regarding the first level appeal. You should write to us following the procedure outlined above under first level appeals. Another dental consultant who was not involved in any prior determinations will review your appeal. In the case of claims for specialty services, a dental consultant duly qualified in the specialty area in question will review the claim. We will notify you of our decision within 30 calendar days of our receipt of the appeal. In accordance with Rhode Island state law, for RI residents and/or where services are to be performed in RI, we will provide you with notice within 15 business days after we receive the appeal. For appeals involving emergency medical conditions, refer to the **Expedited Reviews** section below.

If an adverse determination is issued as a result of the second internal appeal, you then have the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where you are a member of a governmental plan, church plan, or a plan not established or maintained by an employer. You also have the right to an external review through an independent agency. This concludes the internal appeals process.

To initiate an external appeal, you must file a written request for external review with Altus Dental within 60 calendar days of receipt of the second appeal adverse determination notice. External appeals are available only in cases where your claim was denied based on a failure to meet our utilization review guidelines. The external review will be conducted by an independent review agency. You are required to pay 50% of the cost of the external review. Altus Dental pays the remaining 50%. You must include with your request a check for your half of the cost. Please refer to the second appeal adverse determination notice that Altus Dental sent to you for fees associated with this level of appeal or call Customer Service toll free at 877-223-0588. You will be notified directly by the review agency regarding the outcome of your appeal. If the external review agency overturns Altus Dental's decision, we will reimburse you within 60 days of the notice of overturn for your half of the fee. If your claim continues to be denied, you have the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where you are a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

Expedited Reviews

If your claim involves an emergency medical condition whereby the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured in serious jeopardy, then you have the right to an expedited review. For expedited reviews, Altus Dental will complete its review and make a final determination within 2 business days after receipt of the claim, provided all information necessary to complete the review is received.