DELTA DENTAL OF RHODE ISLAND CONSUMER RIGHTS AND APPEALS

Claims Procedures
Call Customer Service if you have a question about how a claim paid, or why it denied. The number is **800-843-3582**. Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m. ET, and Friday from 8 a.m. to 5 p.m. ET. You have a right to request a full and fair review of your claim. **To consider a claim for payment, we must receive it within 12 months of the date you receive the service.** If you or your dentist are located in Rhode Island, your dentist may speak with our dental consultants (licensed dentists) before we make an initial adverse decision. This right is in accordance with Rhode Island law. Your dentist may do this by noting the request on the claim form.

Pre-treatment Estimates / Prior Authorization
A pre-treatment estimate / prior authorization is a claim that is filed before you have a dental service.

**Pre-treatment Estimate**
When treatment is likely to cost more than $300, you and your dentist are strongly encouraged to get an estimate before you receive treatment. This includes treatment such as crowns; periodontic; prosthodontic; and orthodontic services.

**Prior Authorization**
**Prior authorization is required for medically necessary orthodontic treatment if covered by your Plan.** Medically necessary orthodontics is covered for dependent children under age 19 if your plan includes coverage for pediatric dental essential health benefits in accordance with the federal Affordable Care Act. Refer to the Benefits Summary pages of your Certificate. The treatment must meet our criteria. **No payment will be made if prior authorization is not obtained.**

After your dentist sends a request, we will review the treatment plan. After reviewing the treatment plan, we will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if you had other services paid for after the estimate, and you reach your annual maximum, there will be no money left to pay for the new service. Another example is if you lose coverage before the new service is finished.

We must have all of the information we need to review the treatment plan; and, to make a benefit decision. We will send you our initial decision in writing. Generally, we will send our decision within 30 business days. For RI residents, or for services to be done in RI, we will give you an adverse benefit decision in accordance with the timeframes set by RI law. In RI, for non-urgent and non-emergency cases, we will give you an adverse benefit decision within 15 business days; and, prior to the proposed date of service. For urgent or emergency cases, we will give you an adverse benefit decision within 72 hours. Decisions for medically necessary orthodontics will be sent within 15 calendar days.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you get our notice to file an appeal.

Post-service Claims
A post-service claim is a claim that is filed after dental care has been received. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. We will send you written notice of an adverse benefit decision. You will receive this notice within 30 calendar days of the day we receive the claim. We will send you a notice if we can't process a post service claim because information is missing. The notice will be sent to you within 30 days. It will tell you what additional information we need to process the claim. A participating dentist must give us the information we need to process a claim. If not
provided, the dentist may not charge the patient for any un-paid amount. Refer to the Expedited Reviews section for claims involving emergency medical conditions.

We will pay your claim within 40 days after receipt of a complete paper claim; and, within 30 days after receipt of a complete electronic claim. A complete claim has all the supporting documentation we need to make a claim decision. If we do not pay within this time, we will pay interest on the amount not paid. Interest will be paid at a rate of 12 percent per year in accordance with applicable law.

If the service is denied, the notice will explain the reason(s) for the denial. It will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you receive our notice to file an appeal.

**To Appeal an Adverse Benefit Decision**
If you receive an adverse benefit decision, you have the right to have it reviewed. There are two types of appeals and different levels of appeal available depending on the reason a claim was denied. Adverse benefit decisions not involving a determination of dental necessity (e.g., decisions based on eligibility, non-covered services, exclusions and limitations on services, etc.) are allowed one level of internal appeal. Adverse benefit decisions based on a service not being dentally necessary and appropriate as per our review guidelines are allowed two levels of internal appeal and an external review. Please note that, under certain circumstances, once the internal appeals process is exhausted, the member may also have the right to bring a civil action. This right is given under Section 502(a) of the ERISA Act. The member does not have this right if he/she is a member of a governmental plan, church plan, or a plan not established or maintained by an employer. If you feel that we did not follow the appeals process as described in this notice, you may contact: Office of Managed Care Regulation, Rhode Island Department of Health, Room 410, Providence, RI 02908, 401-222-6015, DOH.ManagedCare@health.ri.gov.

You must send us your request for an appeal within 180 days from the date you receive our notice. The Explanation of Benefits or Pre-treatment Estimate notice has numbered messages. These messages explain the reason(s) for the denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria we used to make the denial. You have the right to see copies of all documents related to the claim. We will also give you a copy of any internal rule, guideline, or protocol we used. We will also explain the scientific or clinical judgment we used to decide the claim. We will give you this information, if you ask for it, at no charge.

**To start the 1st and 2nd level of appeal**, you must do so in writing. For an urgent or emergency care request*, you may call Customer Service to start an appeal. You have 180 calendar days to make your appeal. The time starts from when you get our denial notice. **Send your appeal to: Delta Dental of Rhode Island, Attn: Appeals, P.O. Box 1517, Providence, RI, 02901-1517.** Your appeal should ask for reconsideration noting the reason why you believe the service was wrongly denied. It should contain a copy of the Explanation of Benefits or Pre-treatment Estimate notice. You should include the patient’s name; the subscriber identification number; and, a detailed description of your concern. Appeals involving coverage decisions based on dental necessity should also include clinical treatment notes; narratives; photos; x-rays; charting; and, any other necessary clinical documentation that supports your claim. To be covered, services must meet the criteria in our review guidelines found at deltadentalri.com. Your appeal will be evaluated based on material in the file. If the file is incomplete, an incorrect decision could be reached. It is in your interest to add any information that is relevant to considering the appeal. **Before sending a second appeal, you have the right to inspect the review file and add information to the file.**

Additional information must be sent in writing and will be held confidential in accordance with applicable state and federal laws. A dentist will review your appeal if the decision involved a review for dental necessity and appropriateness. On second appeal, for claims involving specialty services done by a specialist, a dentist skilled in the specialty area in question will review the appeal.

**Review Time Frames – 1st & 2nd Appeals**
We will send you our appeal decision in writing. For appeals not involving a determination of dental necessity, we will send our decision within 30 calendar days from when we received your appeal. For appeals involving a determination of dental necessity, we will give you our decision within 15 business days from when we received your appeal. Notice of appeal decisions for medically necessary orthodontics will be sent within 15 calendar days. A decision is made within two business days, if your appeal involves an emergency medical condition.
External Review Option
External appeals are offered only when a claim is denied based on a failure to meet dental necessity as per our review guidelines, and only after the second appeal process is complete. You have 60 calendar days from the date you receive the second appeal adverse benefit decision to send your request to us in writing. All documentation reviewed by our dental consultants will be sent to the review agency. You must pay 50% of the cost of the external review. We pay the remaining 50%. You must include with your request a check for your half of the cost. The second appeal denial notice contains the fees for this level of appeal; or, you can call Customer Service at 800-843-3582. The review agency will notify you directly about the outcome of your appeal. If the external review agency overturns our decision, we will reimburse you within 60 days of the notice of overturn for your half of the fee.

External Review Option for Members Under Age 19 Where Plan Includes Coverage for Pediatric Dental Essential Health Benefits in Accordance with the Federal Affordable Care Act
If your plan includes pediatric dental essential health benefits for children under age 19, the external appeal process for children under 19 is different. (Members age 19 and over follow the process above). External appeals are offered only when a claim is denied based on a failure to meet dental necessity as per our review guidelines, and only after the second appeal process is complete. You have 125 calendar days from the date you receive the second appeal adverse benefit decision to send your request to us in writing. You can add information to the file for review by sending it to us in writing within 5 business days after starting the appeal. In addition, all documentation reviewed by our dental consultants will be sent to the review agency. You must pay $25 (up to a maximum of $75 per plan year per appellant) toward the cost of the external review. The fee may be waived if paying it would cause you undue financial hardship. We pay the remaining cost. You must include a check for your share of the cost with your request. The review agency will contact you directly about the outcome of your appeal.

Expedited Reviews
If your claim involves an emergency medical condition, you have the right to an expedited review. An emergency medical condition is when the insured must see a doctor right away to prevent permanent damage or death. For expedited reviews, we will complete our review and make a final decision within two business days. We must receive all of the information needed to review the claim. Call Customer Service to obtain an expedited review.

*An “urgent care request” means a request for a service where the time periods for making a decision for a non-urgent care request: (a) could seriously risk the life or health of the insured; or, the ability of the insured to regain maximum function; or (b) in the opinion of a physician with knowledge of the insured’s medical condition, would subject the insured to severe pain that cannot be adequately managed without the service.

An “emergency care request” means a request for a service where the insured has a medical condition with acute symptoms of sufficient severity. Symptoms include severe pain, such that a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the lack of immediate medical attention would result in serious damage to bodily functions; serious failure of a bodily organ or part; or would place the person’s health at serious risk.

11/01/16

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY
Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.