Dental Plan Complaints and Appeals Process

Questions and Complaints

Rhode Island defines "Complaint" or "Grievance" as an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or provider. The appeal of an adverse benefit determination is not considered a complaint or grievance.

For questions, complaints or grievances, please call the toll-free number found on your ID card. If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

Rhode Island Consumer Assistance Program

Rhode Island's Office of the Health Insurance Commissioner provides assistance with questions, complaints and concerns through its consumer resource program RIREACH (Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline). RIREACH provides direct assistance to consumers who need help understanding and accessing their health coverage and is available to assist you at 1-855-747-3224 or www.RIREACH.org.

Adverse Benefit Determinations

An adverse benefit determination is a decision made by us, in accordance with the terms of the Policy, to deny, reduce, terminate, or not pay for (in whole or in part) a benefit. Adverse benefit determinations include those based on your or your dependent's eligibility for coverage (for example, a rescission of coverage) as well those based on Utilization Review. Adverse Benefit Determinations include:

Administrative adverse benefit determinations means any adverse benefit determination that does not require the use of dental judgement or clinical criteria such as a determination of an individual's eligibility to participate in coverage, a determination that a benefit is not a covered benefit, a determination that an administrative requirement was not followed or any rescission of coverage; and;

Non-Administrative adverse benefit determinations means any adverse benefit determination that requires or involved the use of dental judgement or clinical criteria to determine whether the service reviewed is necessary and/or appropriate. This includes the denial of treatments determined to be experimental or investigational.

Appeals

- **Post-service Claims**: Post-service claims are claims filed for payment of Benefits after dental care has been received.
- **Pre-service Requests for Benefits:** Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving dental care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- ✓ The member or patient's name and the identification number on the ID card.
- ✓ The date(s) of medical service(s) or date of notification of rescission of coverage.
- ✓ The provider's name, if applicable.
- ✓ The reason claim should be paid or coverage reinstated.
- ✓ Any documentation or other written information to support your request.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits, the claim denial or date of notification of rescission of coverage.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations: Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review Process

After you complete the internal appeal process, if you remain dissatisfied with our final appeal determination, you may request an external review through an outside Independent Review Organization (IRO). There is no minimum dollar amount that a claim must be in order to file an external appeal.

The external appeal is voluntary. An external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the IRO.
- A decision by the IRO.

To request an external review, you must submit your request in writing to us within four (4) months of your receipt of our appeal review determination. A request for an external review of an urgent appeal may be made verbally. We will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, if your request is eligible for external review, we will forward your request to the IRO within five (5) business days for non-urgent appeals, or two (2) business days for an urgent appeal. We will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant dental records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the IRO.

The IRO will notify you of its determination within ten (10) days for non-urgent appeals, or two (2) days for urgent appeals, after it receives this information. The determination of the IRO is binding upon us.
You may contact us at the toll-free number on your ID card for more information regarding external review rights.

For more information, please call the toll-free member phone number on your plan ID card.