

APPENDIX A

(1) Denial of payment based upon lack of coverage of benefit under the Contract or Subscriber's eligibility status i.e., claim benefit determinations that are **not** considered Utilization Review under Article 49 of the New York Insurance Law.

If a post-service claim¹ is denied in whole or in part, Delta shall notify the Subscriber and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fifteen (15) days, for processing. If there is an extension, the Subscriber and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Subscriber or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Subscriber or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta – will begin to run from the date on which the Subscriber's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Subscriber to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta's claim review and appeal process and the time limits applicable to such process. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request).

If the Subscriber or the attending dentist wants the denial of benefits reviewed, the Subscriber or the attending dentist must write to Delta within one hundred eighty (180) days of the date on the denial letter. In the letter, the Subscriber or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Subscriber or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

¹ Delta does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

(2) The review shall be conducted on behalf of Delta by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to the Subscriber or the attending dentist upon request. In making the review, Delta will not afford deference to the initial adverse benefit determination.

If after review, Delta continues to deny the claim, Delta shall notify the Subscriber and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta shall send to the Subscriber or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Subscriber is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Subscriber's claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Contract, an explanation is available free of charge upon request by either the Subscriber or the attending dentist. The notice shall also state: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your State insurance regulatory agency."

If in the opinion of the Subscriber or attending dentist, the matter warrants further consideration, the Subscriber or the attending dentist should advise Delta in writing as soon as possible. The matter shall then be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the Subscriber or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with a civil action.

Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e., claim benefit determinations that are considered Utilization Review under Article 49 of the New York Insurance Law.

See Attachment One.

ATTACHMENT ONE

DELTA DENTAL OF NEW YORK'S UTILIZATION REVIEW AND INTERNAL APPEALS PROCEDURES

I. Definitions

- A. Adverse Determination shall mean a determination by a Utilization Review Agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.
- B. Appeal Determination shall mean a determination by Delta Dental of New York's Dental Affairs Committee that a health care service, upon review based on the information provided, is not medically necessary.
- C. Clinical Peer Reviewer shall mean a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who: (1) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession, and (2) is in the same profession and same similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under review.
- D. Clinical Standards shall mean those guidelines and standards set forth in the Utilization Review Plan by the Utilization Review Agent whose Adverse Determination is under appeal.
- E. External Appeal shall mean an appeal conducted by an External Appeal Agent pursuant to Section 4914 of the New York Insurance Law.
- F. External Appeal Agent shall mean an entity certified by the superintendent pursuant to Section 4911 of the New York Insurance Law.
- G. Final Adverse Determination shall mean an Adverse Determination which has been upheld by a Utilization Review Agent with respect to a proposed Health Care Service following a standard appeal, or an expedited appeal where applicable, pursuant to Section 4904 of the New York Insurance Law.
- H. Health Care Provider shall mean a Health Care Service or a facility licensed pursuant to Article 28, 36, or 47 of the Public Health Law or a facility licensed pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law.

- I. Health Care Service shall mean: (1) for purposes of appeals requested pursuant to Paragraph two of Subsection b of Section 4910 of Title 2 the New York Insurance Law, Health Care Service shall mean experimental or investigational procedures, treatments or services, including services provided within a clinical trial, and the provision of a pharmaceutical product pursuant to prescription by the patient's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the Federal Food and Drug Administration to the extent that coverage for such service is prohibited by law from being excluded under the plan, or (2) in all other cases, health care procedures, treatments or services provided by a facility licensed pursuant to Article 28, 36, 44, or 47 of the Public Health Law pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law, or provided by a health care professional, and the provision of pharmaceutical products or services or durable medical equipment.
- J. Subscriber shall mean a person subject to Utilization Review.
- K. Utilization Review shall mean the review to determine whether a Health Care Service that has been provided is being provided or is proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such service, is medically necessary. None of the following shall be considered Utilization Review: (1) denials based on failure to obtain a Health Care Service from a designated or approved Health Care Provider as required under a contract, (2) where any determination is rendered pursuant to Subdivision 3(a) of Section 2807(c) of the Public Health Law, (3) the review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure, (4) any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an Adverse Determination, and (5) any determination of any coverage issues other than whether a Health Care Service is or was medically necessary.
- L. Utilization Review Agent shall mean any insurer subject to Article 32 or 43 of the New York Insurance Law performing Utilization Review and any independent Utilization Review Agent performing Utilization Review under contract with such insurer.
- M. Utilization Review Plan shall mean: (1) a description of the process for developing the written clinical review criteria, (2) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to a set of specific written clinical review criteria, (3) a description of practice guidelines and standards used by a Utilization Review Agent in carrying out a determination of medical necessity, (4) the procedures for scheduled review and evaluation of the written clinical review criteria, and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of Utilization Review.

II. Standard Claims & Appeals Procedure

- A. Claims for Benefits: In the case of a post-service claim² which has been denied on the basis that such service was not dentally necessary, Delta shall notify the Subscriber and

² Delta does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

the attending dentist of its Adverse Determination in writing within a reasonable period of time, but not later than thirty (30) days after the claim is filed. However, this period may be extended one time by Delta for up to fifteen (15) days, if necessary due to the failure of the Subscriber to submit the information necessary to decide the claim. If there is an extension, the Subscriber and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. The notice of extension shall specifically describe the required information, and the Subscriber or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta – will begin to run from the date on which the Subscriber's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

- B. Reconsideration of Adverse Determination: In the event the Utilization Review of a claim results in an Adverse Determination, and this determination was made without attempting to discuss such matter with the attending dentist who specifically recommended the health care service, procedure or treatment, the attending dentist shall have the opportunity to request a reconsideration of the Adverse Determination. Such reconsideration shall be conducted by the attending dentist and the Clinical Peer Reviewer making the initial determination or a designated Clinical Peer Reviewer if the original Clinical Peer Reviewer cannot be available. If the Adverse Determination is upheld after reconsideration, Delta shall notify the Subscriber of the Adverse Determination as provided below in Section III(A).
- C. Informal Inquiry Option: If a claim is denied in whole or in part, a Subscriber may make an informal inquiry regarding general program and eligibility questions by contacting Delta via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.
- D. Non-emergency Appeals of Adverse Determination: In lieu of making an informal inquiry, a Subscriber or his or her attending dentist may choose to appeal the Adverse Determination. The Subscriber may do so within one hundred eighty (180) days, either by writing to Delta or by calling Delta at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Subscriber and the attending dentist within fifteen (15) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. Both the Subscriber and the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.
- E. Notification of Information Necessary to Conduct the Appeal: If Delta requires information necessary to conduct a standard internal appeal, Delta shall notify the Subscriber and the attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta shall request the missing information, in writing, within five (5) business days of receipt of the partial information.

- F. The Review: The review shall be conducted for Delta by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta will not afford deference to the initial Adverse Determination. A clinical examination at Delta's cost may be implemented, along with discussion among dentist consultants. At this point, the Subscriber may also request a hearing.
- G. Final Adverse Determination: Delta shall make a Final Adverse Determination within thirty (30) days of the date the request for appeal is received. Delta shall advise the Subscriber and the attending dentist of the Appeal Determination within two (2) days of the rendering of such determination. Notification of the Final Adverse Determination will be provided in accordance with Section III(B) below.
- H. Appeal to Delta's Dental Affairs Committee: If in the opinion of the Subscriber or the attending dentist the matter warrants further consideration and the Subscriber chooses not to file an External Appeal pursuant to Section 4914 of the New York Insurance Article, the Subscriber or attending dentist should advise Delta in writing as soon as possible. The matter shall be immediately referred to Delta's Dental Affairs Committee. Delta's Dental Affairs Committee, which contains at least one licensed dentist, will review the claim and either approve payment for the dental service or issue an Adverse Determination. If the Dental Affairs Committee requires information necessary to conduct the Internal Appeal, Delta shall notify the Subscriber or attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta shall request the missing information, in writing, within five (5) business days of receipt of the partial information. This stage can include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta is concerned. Recourse thereafter would be to the courts with a civil action or the filing of an External Appeal pursuant to Section 4914 of the New York Insurance Article, if the time period for doing so had not previously expired.

III. Distribution of Information to Subscribers/Attending Dentists Upon Entry of Adverse Determination

- A. Content of Notification of Adverse Determination. A notice of an initial Adverse Determination will include:
1. The specific reason or reasons for the Adverse Determination including the clinical rationale, if any;

2. Reference to the specific plan provisions on which the Adverse Determination is based;
3. Instructions on how to initiate standard and expedited appeals including a description of the Delta's review procedures and the time limits applicable to such procedures;
4. Instructions on how to initiate an External Appeal pursuant to Section 4914 of the New York Insurance Law;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
6. If the Adverse Determination is based on dental necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Subscriber's medical circumstances is available upon request;
7. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

B. Content of Notification of Adverse Determination on Review i.e., "Final Adverse Determination." If after the claim is reviewed, Delta continues to deny the claim, Delta shall send the Subscriber/attending dentist a notice, which contains:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the insured including the specific reason or reasons for the determination, reference to the specific plan provisions upon which the Adverse Determination is based;
2. A clear statement that the notice constitutes the Final Adverse Determination;
3. The insured's coverage type;
4. The name and full address of Delta's Utilization Review Agent;
5. Delta's contact person and his or her telephone number;
6. A description of the health care service that was denied, including the dates of the service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
7. A statement that the Subscriber and the attending dentist may be eligible for an External Appeal and the time frames for requesting an appeal;

8. A clear statement written in bolded text that the forty-five (45) day time frame for requesting an External Appeal begins upon receipt of the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the Subscriber to request an External Appeal;
9. A copy of the standard description of the External Appeal process as developed jointly by the superintendent and commission, including a form and instructions for requesting an External Appeal;³
10. A statement that the Subscriber is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
11. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
12. If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Subscriber's medical circumstances is available upon request;
13. The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your State insurance regulatory agency."

IV. Cooperation with the External Appeal Agent

Delta will facilitate the prompt completion of External Appeal requests by:

- A. Transmitting the Subscriber's dental and treatment records pursuant to an appropriately completed release or release signed by the Subscriber or by a person authorized pursuant to law to consent to health care for the Subscriber and, in the case of dental necessity appeals, transmit the clinical standards used to determine medical necessity for the Health Care Service within three (3) business days of receiving notification regarding the identity and address of the certified External Appeal Agent to which the subject appeal is assigned.
- B. Providing information requested by the assigned certified External Appeal Agent as soon as is reasonably possible, but in no event shall Delta take longer than two (2) business days to provide the requested information.
- C. Providing the form and instructions, developed jointly by the superintendent and commissioner, for the attending dentist to request an External Appeal in connection with a retrospective adverse utilization review determination under Section 4904 of the Insurance Law, within three (3) business days of an attending dentist's request for a copy of the form.

³ Such information will also be provided by Delta within three business days of a request by a Subscriber or a Subscriber's designee.

- D. In the event that an Adverse Determination is overturned on External Appeal, or in the event that Delta reverses a denial which is the subject of an External Appeal, Delta shall make payment for the Health Care Service which is the basis of the External Appeal to the Subscriber.
- E. No fee will be charged by Delta to a Subscriber for an External Appeal.