

APPENDIX A

(1) *Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee'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 Dental shall notify the Enrollee 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 Enrollee 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 Enrollee 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 Enrollee 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 Dental – will begin to run from the date on which the Enrollee'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 Enrollee 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 Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. 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 Enrollee or the attending dentist wants the denial of benefits reviewed, the Enrollee or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In the letter, the Enrollee 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 Enrollee 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.

The review shall be conducted on behalf of Delta Dental 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 Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental 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 Enrollee or the attending dentist upon request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee 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 Dental shall send to the Enrollee or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract

¹ Delta Dental 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 Dental 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.

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provisions on which the benefit determination is based. The notice shall state that the Enrollee 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 Enrollee'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 Enrollee or the attending dentist. The notice shall also state that the Enrollee has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of the Enrollee or attending dentist, the matter warrants further consideration, the Enrollee or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Enrollee 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 Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

(2) *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. 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.
- B. 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.
- C. Determinations
1. 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. This determination is the initial utilization review denial.
 2. 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. This determination is issued in response to a first level utilization review appeal.
 3. 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. This determination is issued in response to a second level utilization review appeal.
- D. Enrollee shall mean a person subject to Utilization Review.
- 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. 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.
 - H. 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.
 - I. 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.
 - J. 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.
 - K. 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 Dental shall notify the Enrollee and 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 Dental for up to fifteen (15) days, if necessary due to the failure of the Enrollee to submit the information necessary to decide the claim. If there is an extension, the Enrollee 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 Enrollee 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 Dental – will begin to run from the date on which the Enrollee'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 Dental shall notify the Enrollee of the Adverse Determination as provided below in Section III(A). If the Adverse Determination is overturned after such reconsideration, Delta Dental shall make payment for the Health Care Service(s). Delta Dental's claim payment will serve as notification of the decision.
- C. Informal Inquiry Option: If a claim is denied in whole or in part, an Enrollee may make an informal inquiry regarding general program and eligibility questions by contacting Delta Dental 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, an Enrollee or his or her attending dentist may choose to appeal the Adverse Determination. The Enrollee may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee 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 Enrollee 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.

² Delta Dental 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 Dental 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.

- E. Notification of Information Necessary to Conduct the Appeal: If Delta Dental requires information necessary to conduct a standard internal appeal, Delta Dental shall notify the Enrollee 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 Dental 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 Dental 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 Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental 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 Dental will not afford deference to the initial Adverse Determination. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.
- G. Rendering of Decision on Appeal of Adverse Determination: Delta Dental shall either approve payment for the Health Care Service(s) or make a Final Adverse Determination within thirty (30) days of the date the request for appeal is received. Delta Dental shall advise the Enrollee and the attending dentist of the appeal decision within two (2) days of the rendering of such determination. Notification of a Final Adverse Determination will be provided in accordance with Section III(B) below. If payment is approved, Delta Dental's claim payment will serve as notification of the decision.
- H. Appeal to Delta Dental's Dental Affairs Committee: If in the opinion of the Enrollee or the attending dentist the matter warrants further consideration and the Enrollee chooses not to file an External Appeal pursuant to Section 4914 of the New York Insurance Article, the Enrollee or attending dentist should advise Delta Dental in writing as soon as possible. The matter shall be immediately referred to Delta Dental's Dental Affairs Committee. Delta Dental's Dental Affairs Committee, which contains at least one licensed dentist, will review the claim and either approve payment for the Health Care Service(s) or issue an Appeal Determination. If the Dental Affairs Committee requires information necessary to conduct the Internal Appeal, Delta Dental shall notify the Enrollee 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 Dental 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 Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other 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 Enrollees/Attending Dentists Upon Entry of Adverse Determination

A. Content of Notification of Adverse Determination (See Exhibit A, attached hereto). 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 Dental's review procedures and the time limits applicable to such procedures and a statement of the Enrollee's right to bring a civil action under Section 502(a) of ERISA upon completion of the second level of review of Delta Dental's Internal Appeals Procedure;
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 Enrollee'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" (See Exhibit B, attached hereto). If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee/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 Dental's Utilization Review Agent;
5. Delta Dental'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 Enrollee 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 Enrollee 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 Enrollee 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. A statement that when the Enrollee completes the second level of Delta Dental's Internal Appeals Procedure, the Enrollee will then have a right to bring an action under Section 502(a) of ERISA;
12. 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;
13. 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 Enrollee's medical circumstances is available upon request;
14. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

IV. Cooperation with the External Appeal Agent

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

- A. Transmitting the Enrollee's dental and treatment records pursuant to an appropriately completed release or release signed by the Enrollee or by a person authorized pursuant to law to consent to health care for the Enrollee 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

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

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

EXHIBIT A

NOTICE OF ADVERSE DETERMINATION

This notice, provided to you pursuant to the requirements of Article 49 of the New York Insurance Law and the United States Department of Labor Claims Procedure Regulations constitutes an Adverse Determination of your claim.

Reasons for the Determination

The NOTICE OF PAYMENT OR ACTION attached hereto outlines the specific reason(s) and the specific plan provision(s) on which the determination was based.

Availability of Clinical Review Criteria Relied Upon to Make this Determination

Upon request and free of charge, Delta Dental will provide to you a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

Instructions on How to Initiate a Standard Appeal & How to Initiate an External Appeal

If you or your attending dentist want the denial of benefits reviewed, you or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783 ***within one hundred eighty (180) days of the date on this notice. Failure to comply with such requirements may lead to forfeiture of your right to challenge this denial, even when a request for clarification has been made.*** You 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. You or your 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. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental 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. If the review of a claim denial is 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 Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you and your attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send you and your attending dentist a notice, similar to this notice. If in the opinion of you or your attending dentist, the matter warrants further consideration, you have two choices: (1) you may continue to avail yourself of Delta Dental's Internal Appeals Procedure and eventually, upon completion of Delta Dental's second level of review, file an action in the courts pursuant to section 502(a) of ERISA; or (2) you may file an External Appeal with the New York Insurance Department. Attached

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hereto is "Standard Description and Instructions for Health Care Consumers to Request an External Appeal." More information on these two options will be provided to you after you complete the first level of review.

**Additional Necessary information which Must be Provided
in Order for Delta Dental to Render a Decision on your Appeal**

If you should choose to avail yourself of Delta Dental's Internal Appeals Procedure, Delta Dental may require additional information in order to render a decision on your appeal. If this is the case, Delta Dental has attached to this notice a separate sheet containing of a list of such necessary information, which also explains why such material or information is necessary. Please submit such information to the address listed thereon. Please also include any other documents, data information or comments which you believe to have bearing on the claim including this denial notice.

EXHIBIT B

NOTICE OF FINAL ADVERSE DETERMINATION

This Notice is to inform you that upon review of your request for appeal of the Adverse Determination of your claim for benefits, **Delta Dental continues to deny your claim.** Attached are copies of the following: (1) a copy of the standard description of and instructions for initiating New York's External Appeal process; and (2) an application form for requesting an External Appeal. Upon completion of the second level of Delta Dental's Internal Appeals Procedure, you will then have a right to bring an action under Section 502(a) of ERISA.

Please note that you or your attending dentist now have a right to file an External Appeal with the State of New York Insurance Department, but you must do so within forty-five (45) days from the date of your receipt of THIS NOTICE. Even though Delta Dental's plan provides for two levels of review, the forty-five (45) day time period for requesting an External Appeal begins upon receipt of THIS NOTICE, the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested. By choosing to request a second level internal appeal, the time may expire for you to request an External Appeal.

Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Availability of Clinical Review Criteria Relied Upon to Make this Determination

Upon request and free of charge, Delta Dental will provide to you a copy of any documents, records or other information relevant to your claim for benefits, as well as any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

1. Coverage Type: _____

2. Description of the Service for which payment was denied:

3. Basis and clinical rationale for the denial:

4. Specific criteria and standards, including interpretive guidelines on which the decision was based:

5. Plan provisions upon which the determination is based:

6. The following is the name, business address, and business telephone number of the Delta Dental representative who has responsibility for Delta Dental's Internal Appeals Procedure:

7. The following is the name, business address, and business telephone number of the Utilization Review Agent, if different from the answer provided in number 6, above:

By: _____

Title: _____

Date: _____