Dentegra.com

Rhode Island Office of Health Insurance Commissioner
Enrollee Complaint Procedure

Dentegra is committed to quality throughout the dental benefit process. If you have any questions about any services received, we recommend that you first talk with your dentist. If you continue to have concerns, please feel free to contact us or print and complete a grievance form.

We will provide notification when any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility or the denial of dental services or claims, You may refer to the appeal process outlined below. All other complaints regarding Our policies, procedures or operations, or the quality of dental services performed by a Contract Dentist, You may call Customer Service at [800-422-4234] or a written complaint may be submitted to:

Quality Management Department
[P.O Box 1860
Alpharetta, GA 30023]

[P.O. Box 6050
Artesia, CA 90702]

Written complaints must include, at a minimum the following information:

- Patient's name
- Primary's Enrollee's name, address, telephone number and identification number
- Contract holder's name
- Treating Dentist's name and location

We will respond to complaints in writing within 30 days from the date We receive the oral or written complaint, unless granted an extension by the Officer of the Health Insurance Commissioner (OHIC).

We will make a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint. A review of the decision will be undertaken if a written request for an appeal of the determination is

made within 30 days of the date of the written determination. We will undertake a full and fair review upon request. We may require additional documents in making such a review. A written response will be provided to You within 30 days after receipt of Your appeal and supporting documentation or a written explanation if additional time is required to issue the results.

Appeals

We will notify You and Your provider if Benefits are denied for services submitted on a claim form, in whole or in part, stating the reason(s) for denial. For notification of initial prospective adverse determinations, We will notify You and Your provider within 72 hours of receipt of all necessary information to complete review of urgent and/or emergent health services; within 15 calendar days of receipt of all necessary information to complete a review of non-urgent and /or non-emergent services and prior to the expected date of service.

You and Your provider have at least 180 days after receiving a notice of denial to send Us a request for review in writing giving reasons why You believe the denial was wrong. You may also ask Us to examine any additional information You include that may support Your appeal.

Appeals of Adverse Benefit Determinations

You and Your provider may appeal any adverse Benefit determination that includes:

- denial of Benefits (in whole or in part);
- reduction of Benefit;
- termination of a Benefit;
- failure to provide or make a payment, in whole or in part, for a Benefit; and
- rescission of coverage even if there is not adverse effect on any Benefit.

Send Your appeal to Us at the address shown below:

[Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023]

We will review all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original determination, nor the subordinate of that individual.

Upon request, We will provide You with:

- copies of any documents that are relevant to the Benefit determination;

- a copy if the internal rule, guideline, or protocol; and
- an explanation of any scientific or clinical judgment used in making the adverse Benefit determination.

If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatments, or clinical judgement in applying the terms of the Contract, We will consult with a provider who has appropriate training and experience. If any consulting provider is involved in the review, the identity of such consulting provider will be available upon request. The review will be conducted for Us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

We will make a full and fair review within 30 days after We receive the appeal. We may ask for more documents if needed. We will send You a written decision within 30 days. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. For urgent and emergent situations, We will notify You and Your provider of our decision not later than 72 hours after We receive the appeal.

External Review

No later than four (4) months after the receipt of a notice of the decision on a final internal appeal, You may file a request for an external review. All requests for external review must be submitted in writing to Us. We will send the external appeal to an Independent Review Organization that has been approved by the Office of the Health Insurance Commissioner ("OHIC"). Within 5 business days from the date, We receive notice of Your request for an external review, We will send to the independent review organization ("IRO") our documents and any information considered in making the adverse determination including:

- the complete file upon which the adverse decision was based including the specific; findings in the adverse determination; and
- the specific review agency criteria utilized in making the adverse determination.

In making its decision, the IRO will consider:

- the review criteria utilized by Us to make the denial;
- the medical necessity for the care, treatments, or services denied;
- the appropriateness of the service delivery which was denied; and
- other documents submitted by Us, You, or Your treating provider.

You will be notified that you will have at least five (5) business days from receipt of the external appeal notice to submit additional information to the IRO.

Within 10 calendar days after the date of receipt of all information necessary to complete the external review and not more than forty-five (45) calendar days after receipt of the request, the IRO will provide written notice of its decision to uphold or reverse the adverse determination to You. An expedited external review decision will be issued within seventy-two (72) hours after the date of receipt of the request.

The decision of the IRO is binding on Us; however, any person who is affected by the decision of the IRO is entitled to judicial review.

If You believe there has been a violation of insurance statute(s) and/or regulation(s), You may file a written complaint with the OHIC. You must sign and submit a written complaint. The OHIC will only accept complaints filed by Your designated representative, Your attorney, or an executor and/or administrator or other court approved legal representative of Your estate.

Upon receipt of the written complaint, the OHIC will make an initial determination with respect to standing and jurisdiction. The OHIC will then send an acknowledgment letter to You advising that the OHIC is reviewing the matter. The letter of complaint together with any attachments will be sent to Us for reply. Once the OHIC has concluded its review, a letter will be sent to You stating the OHIC's findings.

You may also contact the Office of Health Insurance Commissioner's Consumer Resource program, RIREACH at [1-855-747-3224] for assistance with complaints and appeals.