



PO Box 1850
Alpharetta, GA 30023-1850

Rec'd
7/30/24

Dental Insurance Plan

administered by



Delta Dental Insurance Company



MB 02 000603 38304 H 4 A
PHILIP RICE
11268 E LINVALE DR
AURORA, CO 80014-3071

July 23, 2024

Re: Case ID: APP-308593

Member Name: Philip Rice
Member ID: 120069648701
Claim Number(s):
202405151796225,
20241356147356,
202404041315688,
20240946124239

Dear Philip Rice:

Thank you for your patience during our review of your concerns. This letter is in response to your inquiry/complaint that we received on July 09, 2024 regarding the pre-treatment estimate and services dated May 9, 2024. You are questioning the processing and request explanation of payment.

The following individual(s) participated in the decision-making:

- Appeal Specialist

Review of your account, we verified you have more than one coverage on file. The order as follows:

Primary plan - AARP Dental Insurance Plan
Secondary plan - Devoted Health Services, Inc.

Per Primary Certificate of Coverage for AARP Dental Insurance Plan page 17 titled Appendix A, Benefits Summary:

* Maximum Benefit (Calendar Year) - \$1,500.00

Reviewed primary pre-treatment estimate number 20240946124239 reveals we approved for filling on tooth 10 and partial approval on crown number 18 in the amount of \$430.50. The disallowed the remaining procedures: buildup on tooth number 18, crown and buildup on tooth numbers 30, 31, fillings on tooth numbers 8, 9, 15, occlusal guard and the periapical films because the contractual maximum has been reached. Per primary group plan AARP, the calendar year maximum is \$1,500.00. The pre-treatment estimate was received on April 3, 2024 and completed on April 10, 2024.

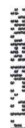
The AARP® Dental Insurance Plan is insured by *Delta Dental Insurance Company* (Contract 1230) in AK, AL, DC, DE, FL, GA, LA, MD, MS, MT, NV, NY, PA, PR, TN, TX, UT, VI and WV, by *Dentegra Insurance Company* (Contract 1230) in AR, AZ, CA, CO, CT, HI, IA, ID, IL, IN, KS, KY, ME, MI, MN, MO, NC, ND, NE, NH, NJ, NM, OH, OK, OR, RI, SC, SD, VA, VT, WA, WI and WY, and by *Dentegra Insurance Company of New England* (Contract 1230) in MA. For Texas residents your Master Policy Form number is TX-AMD-MC-DPO-D-DC(DELTAUSA1-2005).

The plan is administered by Delta Dental Insurance Company. These companies are financially responsible for their own products. Delta Dental is a registered mark of Delta Dental Plans Association.

AARP endorses the AARP Dental Insurance Plan, administered by Delta Dental Insurance Company. Delta Dental Insurance Company pays royalty fees to AARP for use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers.

Customer Service: deltadentalins.com/aarp
866-261-4275

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Reviewed primary service date May 9, 2024 number 20241356147356 reveals primary plan made payment for the filling on tooth number 15 and partial payment on crown tooth number 18 in the amount of \$269.50 on May 22, 2024. We disallowed the remaining of crown and the Periapical First Film (code D0220) because the contractual maximum has been reached. Per primary group plan AARP, the calendar year maximum is \$1,500.00. The claim was received on May 14, 2024 and completed on May 22, 2024.

The following are service dates and Primary paid amounts for 2024:

1. January 4, 2024 \$332.00
 2. January 15, 2024 \$530.00
 3. January 16, 2024 \$87.50
 4. February 2, 2024 \$4.00
 5. February 7, 2024 \$58.00
 6. March 21, 2024 \$58.00
 7. April 16, 2024 \$85.00
 8. April 16, 2024 \$76.00
 9. May 9, 2024 \$269.50
- TOTAL: \$1,500.00

In conclusion, the pre-treatment estimate and services on May 9, 2024 were processed correctly. We regret we are unable to provide you with the response you were hoping for but must remain within the confines of the contract set forth by the group. This completes our review.

Please note, your secondary plan will continue to address your concerns.

A separate letter (referencing GRV-151789) will be sent addressing the service of your coverage dispute.

We appreciate the opportunity to assist you. If you have any questions regarding this matter, please contact the Grievance and Appeals department at 844-580-6096, Monday through Friday from 7:00 am to 5:00 pm Pacific time.

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Sincerely,

My Nguyen

Appeals Specialist

Grievance and Appeals Department

You may request copies of rules or clinical information relevant to this decision. Please write to the address provided below.

You have the right to appeal any adverse decision. If your denial is based on a contractual exclusion you have the right to appeal the applicability of the exclusion by providing evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. If you wish to appeal this decision, please write to Dentegra Insurance Company at the address below as soon as possible:

AARP Dental Insurance Plan
c/o Dentegra Insurance Company
Grievance and Appeal Department
P.O. Box 2059
Mechanicsburg, PA 17055-0759

Your second level appeal shall be referred to our Dental Affairs Committee. The second level appeal may include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested by you or your attending dentist.

You may request the opportunity to appear in person and present materials before the Committee. We will notify you of the date and time of the Committee meeting within 20 days of the scheduled meeting time. The Committee will render a decision within sixty (60) working days of your original request for review as described above.

You have the right to request an expedited internal and external review on a concurrent basis after you receive notice of an adverse determination following your urgent care request.

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Customer Service:
866-261-4275

deltadentalins.com/aarp

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Non-claim Related Complaints and Grievances

If you have any questions about the services you received from Delta Dental or a dentist participating in a Delta Dental network or wish to register a complaint or file a grievance that is not related to non-payment of a claim, you may call us toll-free at 1-866-261-4275. At your request, we will send you a Member Grievance Form for you to complete and send to us describing the nature of your complaint or grievance. If you need help completing the form you may call our Customer Service Center toll-free at 1-866-261-4275 and a representative will assist you in completing the form. Or, you may write to us regarding your complaint or grievance at the following address:

AARP Dental Insurance Plan
c/o Delta Dental Insurance Company
Attn: Grievance & Appeals
P.O. Box 2059
Mechanicsburg, PA 17055-0759

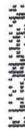
We will provide you with a written acknowledgement of your complaint/grievance within five (5) days of our receipt of your Member Grievance Form. We will conduct an investigation of the circumstances of your complaint/grievance, which may include a request that you provide additional information or a statement setting forth additional factual matters. We will make a written decision within 30 days of receipt of your Member Grievance Form, unless we do not have all of the information necessary to render a decision. In such case, we will advise you of any extension of the time limit for rendering a decision.

If you are not satisfied with the determination on your complaint or grievance, you may appeal this decision by sending us a letter. Your letter should state why you feel the grievance or complaint should not have been so determined. Also, any other documents, data, information or comments which are thought to have bearing on the complaint should accompany your letter to Delta Dental requesting an appeal review. Please send your appeal letter and related documentation to the following address:

AARP Dental Insurance Plan
c/o Delta Dental Insurance Company
Attn: Grievance & Appeals
P.O. Box 2059
Mechanicsburg, PA 17055-0759

Once Delta Dental has received your appeal letter we will send you a letter of acknowledgement. An appellate review will be performed within 30 days of receipt of your letter. The appellate review will take into account all relevant comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. After review, Delta Dental will notify you in writing of the decision on appeal of the complaint or grievance. This decision shall be final insofar as your complaint or grievance is concerned.

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If you have any questions regarding the appeal process or information outlined in this notice, please contact our Customer Service Center, toll-free at 1-866-261-4275.

COAPNOT060329V3

Second Level Appeal

If you or your attending dentist determines that your first level appeal warrants further consideration, you should advise Delta Dental in writing as soon as possible. This is considered a second level or final appeal. The second level appeal will be immediately referred to our Dental Affairs Committee. This final appeal may include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will meet and will render a final decision within sixty (60) business days of receipt of your appeal of the claim denial. You will be notified twenty (20) days prior to the Dental Affairs Committee meeting of the date and time and you will be provided the opportunity to appear in person at the meeting. Delta Dental may request that you or your provider submit any additional materials you wish to present to the Dental Affairs Committee at least five (5) days prior to the scheduled meeting. You may also request that Delta Dental provide you, within five (5) days of the meeting, any additional information you require for the meeting. If you elect to obtain an attorney to represent you during the appeals process, please notify Delta Dental of the representation at least seven (7) days prior to the meeting. You will be notified of the decision of the Dental Affairs Committee within seven (7) days of completion of the meeting. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. If your second level appeal is denied, you will receive a final adverse decision letter.

Independent External Review – Colorado Division of Insurance

If a review determination has been made resulting in a final adverse decision (including a denial on the basis that the requested service is experimental or investigational); (ii) you are covered under a contract issued in Colorado (whether or not you reside in Colorado); and (iii) you have either exhausted the appeals procedure; you have received a denial on expedited appeal; we have declined to process your request for an expedited appeal as expedited; or you wish to proceed without filing a second level appeal, you may appeal the final adverse decision to the Colorado Division of Insurance by submitting the attached form (Appendix A) to Delta Dental Insurance company at:

AARP Dental Insurance Plan
c/o Delta Dental Insurance Company
Attn: Grievance & Appeals
P.O. Box 2059
Mechanicsburg, PA 17055-0759

A copy of the form will be submitted by Delta Dental to the Colorado Division of Insurance within two (2) working days of receipt. If we receive your request for Independent External Review and reverse our adverse decision at that time, we will notify you within one (1) working day of the reversal, either electronically, by fax or by telephone followed by a written confirmation. The Colorado Division of Insurance will assign an independent entity to conduct the external review within two (2) working days of receipt of the request. Delta Dental will notify you electronically, by fax or by telephone, of the identity of the independent entity within two (2) working days of receipt of the notification from the Colorado Division of Insurance of the assignment. The independent external review entity shall provide its decision in writing within thirty (30) days of the request for external review.

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Once Delta Dental has received your appeal, we will send you a letter of acknowledgement. The appellate review will be performed within 30 days of receipt of your letter, so long as all information necessary to perform the review has been submitted. If all information needed to make a determination is not received, you will be notified and provided an additional 45 days to submit the additional information for consideration. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. If after review, Delta Dental continues to deny the claim, we will notify you and your attending dentist in writing of the decision.

The appeal will be conducted by a dentist who is neither the person who originally made the claim denial that is subject of the appeal nor a subordinate of such individual. If the appeal is based in whole or in part on the lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the plan offering, the appellate review will be performed by a dentist who has appropriate training and experience in the pertinent field of dentistry. The identity of the dentist will be provided in any decision letter and is also available to you or your dentist by contacting our Grievance and Appeals department.

Expedited Appeals

If your appeal involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function, you or your attending dentist may request that Delta Dental review your claim on an expedited basis. Delta Dental will evaluate your request for an expedited appeal and if your request for review qualifies as an urgent appeal, we will process and make a decision regarding your appeal within one (1) business day from receipt of all necessary information. If all required information is not provided at the time of the expedited appeal request, Delta Dental will contact you orally or, if requested by you, in writing within 24 hours of receipt of the request notifying you of the information needed. You will be provided no less than forty-eight (48) hours to submit the additional requested information. Delta Dental will then provide a determination within forty-eight (48) hours of receipt of the additional information.

If your expedited appeal results in a final adverse decision, we will immediately notify you or the person who requested the expedited review on your behalf of the final adverse decision and will notify you, by telephone, facsimile, or electronic mail, that you are eligible for an expedited appeal to the Bureau of Insurance. The notification shall be followed within 24 hours by written notice to you and your treating provider, clearly informing you of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal to the Bureau of Insurance may be filed. A copy of the written notice shall be retained by us and included with any materials forwarded to the Bureau of Insurance in the event our decision is appealed to the Bureau of Insurance.

If we determine that your appeal does not qualify as an urgent appeal, that decision will be considered a final adverse decision and we will follow the same procedure and provide you with the same notice as outlined in the preceding paragraph.

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AARP® DENTAL INSURANCE PLAN COMPLAINT SYSTEM

This document describes Dentegra Insurance Company's Complaint System for enrollees in the AARP Dental Insurance Plan covered by a policy written in Colorado. The Complaint System is administered by Delta Dental Insurance Company ("Delta Dental"), as plan administrator and covers your right to appeal a denial of a claim and to register any non-claim related complaint or grievance. Please read this document carefully. It will provide you with information regarding your rights and how you may exercise those rights. If you have any questions regarding this process or need assistance in completing forms, please contact our Grievance and Appeals department toll-free at 1-866-261-4275.

Claim Appeal Process

If your claim is denied in whole or in part there is an appeal process available to you. The Notice of Payment that you received which contains information regarding the payment or non-payment of your claim outlines the specific reason(s) and plan provision(s) upon which the determination of payment or non-payment was made. The complaint/appeals process outlined on the reverse side of the Notice of Payment is superseded by this document. Please follow the procedures outlined in this document to appeal a claim denial. You may request, free of charge, copies of any internal rule(s), guideline(s), protocol(s) and or an explanation of the scientific or clinical judgment that was relied upon to deny your claim.

Reconsideration of your claim may occur when your dentist re-submits the original claim and provides additional information which allows processing of the claim to be completed.

First Level Appeal

If a claim continues to be denied after reconsideration, and you or your attending dentist would like to appeal the denial of benefits, you may file an appeal by writing to Delta Dental within one hundred eighty (180) days of the date you received the Notice of Payment that contained the denied services.

Your letter should state why the claim(s) should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim(s) including the denial notice, should accompany your letter to Delta Dental requesting an appeal review. Please send your appeal letter and related documentation to the following address:

AARP Dental Insurance Plan
c/o Delta Dental Insurance Company
Attn: Grievance & Appeals
P.O. Box 2059
Mechanicsburg, PA 17055-0759