TRUASSURE INSURANCE COMPANY (TAIC)

CLAIMS APPEAL PROCEDURES

Prior Approval of Benefits: This group dental plan does not require prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, TAIC shall notify the Subscriber of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. TAIC will notify the treating Dentist as well by issuing an Explanation of Payment. If an extension is necessary, TAIC shall notify the Subscriber and the treating Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the Subscriber or the treating Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;
- A description of TAIC's appeal process and the time limits applicable to the process, including a statement of the Subscriber's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA following an adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Request for Appeal of Adverse Benefit Determination: If the Subscriber disagrees with TAIC's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of TAIC within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that TAIC's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Your appeal should be addressed as follows:

TruAssure Insurance Company
Attn: Reevaluation Committee
111 Shuman Boulevard
Naperville, Illinois 60563

Upon request, TAIC will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific plan provisions upon which the determination is based;
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request;
- A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.