TRUASSURE INSURANCE COMPANY

CLAIMS APPEAL PROCEDURES

Prior Approval of Benefits: TruAssure Insurance Company does not require prior approval of dental services. Nonetheless, you or your dentist may request a pre-treatment estimate. A pre-treatment estimate is a request your dentist sends to us to find out how much we will pay for a dental service that is covered by your dental plan before treatment begins. A pre-treatment estimate gives you and your dentist an idea of how much we will pay your dentist and how much you will owe for a service. A pre-treatment estimate is only an estimate and not a guarantee of payment. Estimated payment may be less after treatment is completed due to a change in your or a family member's eligibility, your deductible has been met or renewed, or you exceeded the limit for your annual maximum by receiving other dental services not included in the pre-treatment estimate.

Notice of Claim Denial: If a claim is denied in whole or in part, we will notify you of the denial in writing, by issuing an Explanation of Benefits. The claim will be processed within the timeframe required by state law including any applicable extensions. We will notify the treating dentist as well by issuing an Explanation of Payment.

Notice Contents: Each claim denial will include the following information on the Explanation of Benefits:

- 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 TruAssure'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 a claim denial or 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 claim denial or 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 claim denial or adverse benefit determination is related to dental necessity, experimental treatment, or other similar exclusion or limitation.

Request for Appeal of a Denied Claim: If you have questions about the denial of a claim, you should contact us at 888-559-0779. Most questions about benefits can be answered over the phone. We encourage you and covered family members to first talk with our customer service team to try to fix any issues. If we can't reach a solution, you or your covered family members have the right to appeal our claim decision and request that we formally review your claim. You may appeal in writing a claim that is denied within 180 days from the date on the denial notice or the time allowed by state law. You should provide the reasons why you disagree with our decision and include any additional documents in support of your appeal. You should include your name, any related dependent's names, if applicable, and your member ID number on all documents.

Your appeal should be addressed as follows:

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

Upon request, we 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: After we receive your appeal, we will review your request in the time required by state law. We will take into account all comments, documents, records, or other information submitted, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted by a person who did not make the initial claim denial. If the review is of a claim denial based in whole or in part on a 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 not the dental consultant who made the initial claim denial.

Notice of Review Decision: The Reevaluation Committee shall notify you in writing of its decision on the appeal within the time required by state law and provide you with a new Explanation of Benefits.

If we grant your request, the decision will authorize the service or pay the claim and the appeal review is complete.

If you disagree with our decision regarding your appeal, you may request a second review. You must send a written request to us at the address listed above. Please include any additional information you or your dentist can send regarding your claim so that we can reconsider our decision.

Confidentiality: Dental records remain confidential. TruAssure Insurance Company follows all state and federal laws regarding privacy of dental records. If you participate in the appeal process, the relevant portions of your dental records may be disclosed only to persons authorized to participate in the review process for the dental condition under review. These select persons may

not disclose your dental information to any person who is not involved in the appeal review process.