Complaint Procedures

Complaint Resolution. If you have a concern or question regarding the provision of Dental services or benefits under the policy, you should contact the PLAN's Customer Care Center at the telephone number shown on the back of your plan ID card. Customer Care representatives are available to take your call during regular business hours, Monday through Friday. If you would rather send your complaint to us in writing, please send to:

FOR MEMBERS AND OTHERS:
Member Appeal Information:
Dental Appeals and Grievances
Central Escalation Unit
P. O. Box 30569
Salt Lake City, UT 84130-0569

FOR NETWORK PROVIDERS:
Provider Appeal Information:
Dental Appeals and Grievances
Central Escalation Unit
P.O. Box 30569
Salt Lake City, UT 84130-0569

If the Customer Care representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after following the above steps, you can ask us to formally reconsider your complaint, either orally or in writing. The Customer Care Representative can provide you with information on the appeal process. The telephone number is located on the back of your plan ID card.

Appeal Process

Each time there is an adverse determination, we will notify you of your right to an appeal of our decision. If coverage denial is involved, we will include instructions for filing a request for review by the Kentucky Department of Insurance.

You, an authorized person or a provider acting on your behalf may request an appeal within 60 days of receipt of our initial denial letter or if we fail to make a prior authorization determination and provide notice within the required time frame. A licensed Provider who did not participate in the initial review and denial will conduct the appeal of an adverse determination.

We will consider any portion of your record(s) that may be relevant to the appeal, with your authorization. Providers will also have the opportunity to submit any additional information for the appeal.

We will provide a decision within 30 days of receiving the request for the appeal.

You have the right to take your complaint to the Kentucky Department of Insurance if you are not satisfied with our decision regarding a coverage denial. The Kentucky Department of Insurance will notify us, if they determine a service is not specifically limited or excluded. We will either cover the service or allow you the opportunity for an external review, which is discussed below under the heading External Review Program. The address and telephone number for the Kentucky Department of Insurance is as follows:

Kentucky Department of Insurance
Complaints Department
P.O. Box 517
Frankfort, KY 40602-0517
(502) 564-6088
(800) 595-6053

If you, an authorized person, or a provider acting on your behalf has new clinical information regarding the internal appeal, please provide the information to us prior to initiating the external review process. We will provide a decision based on the new information within 5 business days from the date of its receipt.

External Review Program: You or an authorized representative or Provider may request a written or oral external review, in writing, within 60 days of receiving notice of the decision made in the internal appeal process. The request should include a statement authorizing the release of your records to the independent review entity. For information on the external review process, contact the Appeals Coordinator at the number on the back of your plan ID card.

We will provide for an external review of a coverage denial that requires the resolution of a medical necessity determination issue. An external review will also be provided for an adverse determination if the following criteria are met:

- We have made an adverse determination.
- You have completed the internal appeal process; we have failed to provide a decision within the required timeframes; or you have agreed with us to waive the internal appeal process.
- You were a member of the Enrolled Group on the date of service.
- The entire course of treatment or service will cost the Covered Person at least $100, if we do not provide coverage.

The external review will be conducted by an independent review entity certified by the Kentucky Department of Insurance. We will rotate independent review entities to ensure that same person does not conduct 2 consecutive external reviews.

You will be charged a one-time filing fee of $25 to the independent review entity. The fee may be waived, if it is determined that it will create a financial hardship. The fee will be refunded if the independent review entity finds in your favor. We will pay for all costs other than the initial $25 filing fee and will comply with the decision of the independent review entity.

After receiving a request for the external review, the independent review entity will provide a decision within 21 calendar days of receipt of the request. A 14-calendar day extension may be allowed if all parties agree. The entire external review process and any medical, dental records are confidential.

An external review of an adverse determination will not be provided to you if:

- The subject of your adverse determination has already gone through the external review process and the independent review entity found in our favor; and
- There has been no new, relevant clinical information submitted to us since the independent review entity found in our favor.

If there is a dispute regarding your right to an external review, you may file a complaint with the Kentucky Department of Insurance.

Expedited External Review: You may request an expedited external review if you are hospitalized or your treating provider believes that a delay in treatment would increase the risk to your health (or that of your unborn child); seriously impair bodily functions; or cause serious dysfunction of a bodily organ or part. You may submit an oral request, followed by a brief written request to us, for an expedited external review.

If you request an expedited external review, we have 24 hours to forward the request to the independent review entity. The independent review entity has 24 hours from the date he/she receives notice of the adverse determination to make a decision. A 24-hour extension may be allowed if all parties agree.