PRINCIPAL LIFE INSURANCE

COMPANY GROUP DENTAL EXPENSE INSURANCE

CLAIM INFORMATION

To submit a claim to Principal Life Insurance Company, most dental claim forms are accepted. Important fields must be included on the form:

- Attending Dentist's Statement to determine pretreatment estimate or actual charges.
- Member's name and claim identification.
- Patient's name.
- Other insurance information.
- Signed authorization to pay.
- Dentist's name and location identification plus their Tax Identification (TIN).
- Procedures and charges and dates of service and occurrences.
- Provider's signature and the date it was signed.
- Answer the question, "Are any services covered by another plan?"

Claims can be submitted electronically, or mailed to:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392

A toll-free number is provided on all Member I.D. Cards for provider questions.

Principal Life claim adjudication process is composed of claim processor, claim examiner, and on-line claim system interaction.

Written proof of loss must be sent to The Principal within 12 months after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient’s name, Member’s name (if different from the patient’s name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with The Principal's request could result in declination of the claim. The Principal may also require x-rays, dental charts, and other evidence needed to determine the dental

condition treated and the services provided. Failure to provide proof within the time specified will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible.

Incoming mail is opened, date stamped, and reviewed for an account number. If no account number is provided, the mail is indexed via the on-line claim paying system. If it cannot be identified as pertaining to a plan provided by Principal Life, it is returned to the sender with a request for additional information.

Electronic claims are processed in the same manner as paper claims. Mail is processed in the order it was received and will be processed within 40 calendar days from the mail received date. Electronic claims submitted by dental providers will be processed within 30 days.

When mail is identified as pertaining to a plan provided by Principal Life, careful review of the claim by the examiner begins. With our interactive claim processing, the processor or the examiner reviews and considers the claim, assisted by our on-line claim paying system.

Upon receipt of the claim, the processor indexes general employee/claimant/provider information in the system to confirm eligibility and accurate identification. Verification information includes employee name, address, date of birth, the employer or group name, prior claims history by individual and termination of coverage data. The on-line system also provides special information about the individual and/or group, such as special policy language.

After the processor verifies the correct records, the system can provide all prior activity for the claimant, including all benefits paid, correspondence and other applicable claim activities for the processor's review. The claim system also defines parameters of coverage, including detailed analysis of patient status, current and prior dental plan information, eligibility requirements, coordination of benefits data, plan limitations and procedures, types of coverages available and any special plan provisions.

After reviewing this information and analyzing the claim submitted, the processor inputs the following information in the system: the provider of service, amounts charged, dates of service, procedures and services rendered, adjustments for other coverage, etc. The system uses this data to automatically screen for prevailing fee limitations and duplicate charges and to compute, if applicable, the deductibles, coinsurance amounts and maximums.

Claims are processed using our on-line system. Basic claim data is input by Process Specialists and the system automatically adjusts many claims based on the data input and programmed system logic. An examiner reviews only those claims that cannot be processed automatically by the system.

If correspondence is needed, the examiner requests the appropriate type from the on-line system for automatic printing and mailing.

Our on-line system immediately updates all history, maximum, deductible, statistical and accounting records after completion of the claim transaction. Since our on-line claim paying system updates on a real-time mode, recognition is instantaneous wen the deductible has been satisfied and all subsequent claims are processed accordingly.

Examiner decision areas generally involve variables that cannot be absolutely defined by the on-line system. Such examiner analyses include discovery of potential fraudulent activity, interpretation of dental reports and records, investigation, and discrimination of information supplied on the claim form.

When the payment data has been input, the entire claim record can be reviewed by supervisory personnel before the draft is issued. Security techniques within the claim system limit access to only authorized personnel. Exact details of system security are confidential and limited to departmental management staff.

The actual drafts are printed in the home office and mailed from Des Moines, Iowa.

Senior claim personnel are available to assist the examiner with any questions on difficult claims.

In addition, Principal Life uses dentists that are reimbursed on an hourly basis for reviewing claims. We do not charge the customer for claims referred to the consultants in accordance with our guidelines. When necessary, we request dental treatment records and any other information that would more clearly describe the claimant's condition and treatment and support the necessity of treatment. We may also gather information from the following sources:

- Results of research published in professional journals and books
- Opinions from our Dental Consultants, dental department, and state peer review committees
- Claim practices and procedures manuals and administrative memos that are updated as additional data is accumulated
- Sound claims judgment forged from actual experience
- If warranted, dental peer review organizations where available

Any provider dispute will be handled under the Complaint and Grievance Procedures described in the attached document named Appeals Process and Alternate Dispute Resolution Mechanism.

Interest will be paid beginning on the 30th calendar day for electronic claims and the 40th calendar day for all other claims. Simple interest on the claim amount will be paid at the rate of 12% per year. The interest will be paid at the time the overdue payment is made. Interest will accrue beginning from the date all information and documentation required to process the claim is received.

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GROUP DENTAL EXPENSE INSURANCE

INTERNAL APPEALS PROCESS

In the event of a denial of a claim for service that has already been provided, the member may appeal that denial by filing a written appeal within the timing requirements of state law. Appeals that are received past the filing limitation will be denied as being past acceptable appeal timing.

The member or the member's provider may submit any material justification or documentation with the written mandatory appeal to support the member's request for the claim for service.

Written notification of the outcome of the mandatory appeal will be provided to the member within 60 days after receipt of the written mandatory appeal or a timeframe as specified by state law. The notification will include the criteria used and the clinical reasons for that decision.

If additional information is required in order to process the appeal, the request will be completed within the overall 60-day timeframe or as specified by state law. The timing guideline does not stop or pause when the request for additional information is made.

Additional information will only be requested if it is required to support the member's claim. If the requested information is not received, the appeal will be reviewed based on existing information.

If the initial denial was due to plan limitations, the person performing the appeal review will not be the same person who made the initial benefit determination and will be of equal or higher authority level than the previous handler. The policy/plan provisions initially applied to the claim will be reviewed for accuracy. If additional benefits are due to the patient and/or provider, they will be issued as soon as possible. If the limitations and/or exclusions initially applied are accurate, then the appeal reason and result will be documented in the member's account and the appropriate letters issued to the member/provider.

If the member's complaint is an issue of dental necessity under the coverage and not whether the service is covered, a licensed dentist (Consultant Reviewer) will review the appeal and render a decision based on the utilization review plan. The Consultant Reviewer performing the appeal review will not be the same person who made the initial benefit determination.

If the Consultant Reviewer approves further benefits for the claim, these will be issued as soon as possible but no later than noted in timing guidelines above.

At any time during the formal appeal process, we may request an external, independent review. If we initiate the external, independent review process, we are not required to notify the member of the outcome of the review within 60 days.

If at the conclusion of the formal appeal process, we deny the appeal and we do not initiate the external independent review process, we will provide the member with notice of the option to proceed to an external independent review if required by state law.

If the mandatory appeal process does not resolve an adverse benefit determination, the member or designated patient representative can request a Voluntary Appeal Review. The Voluntary Appeal Review may be requested by telephone, fax or in writing.

Written comments, documents, records and other information relating to the request for the appeal may be submitted by the member, designated patient representative or dental provider. New information must be submitted in order for a Voluntary Appeal to be considered.

We will make a decision within 60 calendar days of request for a Voluntary Appeal or as required by state law. If the appeal cannot be processed due to incomplete information, we will send a written request to the member that includes an explanation of the additional information that is required.

The requested information must be sent within 60 calendar days of the day of our written request for the information or as required by state law. Failure to comply with the request for additional information may result in the declination of the Voluntary Appeal.

A decision will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

If the denial was due to plan limitations, the person performing the voluntary review will not be the same person who made the previous benefit determinations.
If the denial is concerning dental necessity, a licensed dentist (Consultant Reviewer) will review the voluntary appeal and render a decision based on the utilization review plan.

The Consultant Reviewer performing the voluntary appeal review will not be the same person who made the previous benefit determinations.

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UTILIZATION MANAGEMENT

Principal Life is responsible for the day-to-day operations of Utilization Management. Principal Life adheres to the clinical guidelines set by the American Dental Association.

Principal Life will make criteria available, upon request, to covered persons and interested providers except that internal or proprietary quantitative thresholds for UM is not required to be released to covered persons or providers.

When the request is related to a specific treatment or services for which benefits are being sought, the information provided may be limited to all criteria and protocols by which the insurer performs UM relevant to only that treatment or services.

Utilization Management at Principal Life includes the application of practice guidelines and retrospective review only. No pre-admission or pre-authorization reviews continued stay reviews or discharge planning are part of our Dental programs.

The QA/QI program at Principal Life satisfies the New Jersey review requirements for Utilization Management.