American Airlines

APPLICATION FOR FIRST LEVEL APPEAL: ADVERSE BENEFIT DETERMINATION UNDER DENTAL COVERAGE

THIS APPLICATION FOR FIRST LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING YOUR DENTAL COVERAGE, SUCH AS DENTAL COVERAGE LIMITATIONS AND EXCLUSIONS, DENTAL CLAIM DENIAL, ALTERNATE TREATMENT/BENEFIT DETERMINATIONS, 5-YEAR REPLACEMENT LIMITATIONS, ETC.

In order for the Dental Network/Claim Administrator to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep copies of all documentation you submit in support of your First Level Appeal, as this documentation will be required if you choose to file a Second Level Appeal with Employee Benefits Committee (EBC) at American Airlines, Inc. The information you submit is provided at your own expense. You must file this First Level Appeal within 180 days of the date you receive notice of the adverse benefit determination from the Dental Network/Claim Administrator; otherwise, your right to both levels of appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR FIRST LEVEL APPEAL (both employee and patient, other than a minor child, must sign this Application
- Explain, in detail, why you believe your issue in question should be approved by the Dental Network/Claim Administrator
- Include all information and documents that you believe support your appeal
- Attach all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- If this appeal is being filed by your authorized representative on your behalf, include a copy of your signed and dated authorization documenting your permission for the authorized representative to act on your behalf

Additionally, if your appeal involves:

- Dental Usual and Prevailing Fee Limits, you must include any and all itemized bills and procedure/operative reports that you believe warrant additional allowances
- Dental Necessity, you must include recently dated pre-operative x-rays, copies of the clinical records and procedure reports from your treating dentist, and any other clinical documentation on your case
- Time Limits for Replacement of Crowns or Other Restorations, you must include dental records or other documentation of prior placement, if any, and the reason for replacement of the prior restoration
- Alternate Treatment Benefit Allowance, you must send recent dated dental x-rays of the affected tooth, arch, or full mouth series, if appropriate. You must also provide copies of the clinical records from your treating dentist, including treatment plan, and documentation of why your dentist's selected method of treatment was required (as opposed to a less expensive method of treatment)
- Necessity of Dental Implants, you must provide clinical dental records of all missing teeth in the affected arch or arches (identified by tooth numbers), including dental x-rays. Please have your treating dentist provide records of the prior restorative placement, if any, and explanation of the dental necessity and reasons for replacement with dental implants. Please have your treating dentist provide the post-implant restorative treatment plan
- Plan Exclusions, please explain in detail why you believe that the service or supply that was declined qualifies for coverage, providing dental records and clinical documentation that you believe support your case.

Your failure to provide all pertinent documents may affect the outcome of your appeal review.

The Dental Network/Claim Administrator (MetLife) will provide you with a written response to your request for review within approximately 15 days (for pre-service issues) or 30 days (for post-service issues) of its receipt of this completed

Application and supporting documentation. If you disagree with the First Level Appeal determination, you may appeal the decision by filing a Second Level Appeal with the EBC at American Airlines, Inc. **HOWEVER, YOU MUST REQUEST A FIRST LEVEL APPEAL WITH THE DENTAL NETWORK/CLAIM ADMINISTRATOR AND RECEIVE ITS DETERMINATION BEFORE YOU MAY PROGRESS TO THE SECOND LEVEL APPEAL WITH THE EBC**. If you wish to appeal to the EBC, you must complete and sign an Application for Second Level Appeal and mail it, with a copy of the First Level Appeal determination letter and with all supporting documentation, to the EBC. **Your Second Level Appeal must be completed and filed within 180 days of the date you receive the Dental Network/Claim Administrator's decision on the First Level Appeal or your right to further appeal is waived**.

EMPLOYEE'S FIRST LEVEL APPEAL:
The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Employee Benefits Guide**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed).

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TOTAL AMOUNT OF APPEAL (IF KNOWN) $_____

In signing this form, I also authorize the release of all medical records and other information pertinent to this appeal to American Airlines, Inc., Plan Sponsor and Administrator of the American Airlines, Inc. benefit plans, the Network/Claim Administrator and the EMPLOYEE BENEFITS COMMITTEE (EBC), and its agents/delegates, including any health care professional(s) selected by the EBC to assist with the appeal review.

PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:

EE Name:	**Benefit ID#:**
EE#:	**EE Signature:**
SS#:	**Patient Signature:**
Address:	**Date:**
Address:	**Home Phone:**
City:	**Work Phone:**
State:	**Cell Phone:**
Zip:	**Email:**

MAIL COMPLETED FORM AND SUPPORTING MATERIALS TO:

MetLife Group Claims Review
PO Box 14589
Lexington, KY 40512
Fax: 859-389-6505
Phone 866-838-1072