

EXHIBIT E

[REDACTED]

September 16, 2008

[REDACTED]

Re: Group No.: [REDACTED]

Insured: [REDACTED]

Claim No.: [REDACTED]

Company & NAIC #: [REDACTED]

Dear [REDACTED]

We have received your letter of concern regarding a service rendered on 06/24/08 by [REDACTED]. The reasonable and customary fees currently in our system are based on data published by the Health Insurance Association of America (HIAA). In addition, your group policy certificate states under the section titled:

DENTAL BENEFITS

DEFINITIONS

REASONABLE AND CUSTOMARY CHARGE means a charge that is not more than:

>the dentist's usual charge for a dental service; and

>the usual charge made by most other dentists with similar training and experience in the same geographic area.

Please be advised that the reasonable and customary allowance for procedure D2330 (resin-based composite-one surface) of \$250.00 is correct and in accordance with the Health Insurance Association of America (HIAA). Therefore, no further benefits are payable.

We are sorry this decision could not be more favorable, however, we must adhere to the provisions of your group policy. If you have any further questions, please feel free to contact me at [REDACTED].

The Company reserves any and all its defenses which it has or may have with respect to any claim made under this policy.

Sincerely,

[REDACTED]

Senior Dental Claims Examiner
Policy Benefits Department

Enclosure: Second Appeal Process

[REDACTED]

Distributing products issued by: [REDACTED]

Member companies of [REDACTED]

This company does not solicit business in [REDACTED]

[REDACTED]

EXPLANATION OF BENEFITS

EOB No: [REDACTED]

Date: 07/29/2008
Page: 1

[REDACTED]

EOB No. : [REDACTED]
Group : [REDACTED]

Dear [REDACTED]

This is an explanation of benefits for the Dental claim we received in JULY for services rendered to [REDACTED] DOB: [REDACTED]

CLAIM [REDACTED] BREAKDOWN

Provider	Date of service	Procedure	Charge	Inelig.	Ref	Deductible	Paid %	Payment	Paid To
[REDACTED]	06/24/08	PROPHYLAXIS ADULT	165.00	15.00	1	0.00	100%	150.00	PROVIDER
	06/24/08	RESIN 1 SURFACE	450.00	200.00	1	0.00	80%	200.00	PROVIDER

BENEFIT SUMMARY FOR CLAIM [REDACTED]

Charges	Ineligible			Balance		Plan Pays	You May Owe
\$615.00	\$215.00			\$400.00		\$350.00	\$265.00

REFERENCES

Ref #	Explanation
1	This charge exceeds the reasonable and customary allowance under the plan.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ABOVE, PLEASE CONTACT US AT [REDACTED] BETWEEN THE HOURS OF 8:30AM AND 7:00PM, MONDAY THROUGH FRIDAY.

IF YOU WISH TO APPEAL AN UNFAVORABLE CLAIM DECISION, YOU MAY REQUEST A REVIEW BY WRITING TO US WITHIN 2 YEARS OF THIS NOTICE AT:

[REDACTED]

ON ALL CORRESPONDENCE RELATING TO THIS CLAIM, PLEASE REFER TO THE CLAIM NUMBER INDICATED ABOVE.

The [REDACTED] has providers at 100,000+ locations. When using an [REDACTED] provider