DENTAL NETWORK ACCESS PLAN

This section will be the identification and description of the network. Please make sure this section includes at least the following items:

- *full name of the carrier:* **Dentegra Insurance Company**
- *full name of the network:* **Dentegra PPO**
- *carrier's network ID number :* **CON001**
- *type of network and general description :* **PPO**
- *specific geographic area(s) covered by the network :* **Statewide**
- *website identification :* **www.dentegra.com**
- *contact information :* **Dentegra Customer Service (877) 280-4204**

The carrier shall address the following in the network access plan for each dental network offered by the carrier:

1. Network Composition, Identification of Provider Criteria

a. The factors a carrier uses to build its dental provider network, including a description of the network; and

The Dentegra credentialing and re-credentialing process is based on the standards of national, federal and state accrediting and regulatory agencies. Credentialing involves verifying each treating provider's submitted information with regulatory agencies, professional associations and educational institutions to ensure that the provider is legally qualified to practice. Dentegra uses credentialing criteria and guidelines to verify that providers meet and maintain the required standards for contracting in each Dentegra network. To achieve this goal, our credentialing procedures are focused on confirming the following elements:

- **Completed credentialing form that attests to ability to practice**
- **Valid and current license to practice (state license)**
- **Hospital privileges, if applicable**
- **Permits and registrations that are all current, including DEA, conscious sedation, oral conscious sedation and general anesthesia, if applicable.**
- **Board certification of specialty/residency completion/medical school, if applicable.**
- **Current acceptable professional liability insurance coverage limits.**
- **Professional liability claims history, including previous lawsuits, if any.**
- **Application processing – professional questions and attestation.**
- **National practitioner data base (NPDB) information.**
- **Medicare and Medicaid sanctions.**
- **Sanctions against licensure- state license limitations.**
- **Prior work history**

We verify the information provided on the application and forward it to our credentialing committee for final review and contract approval. All information submitted for the credentialing/re-credentialing process is kept confidential.

Dentegra may, at its sole discretion, select Provider for participation, based upon Dentegra's determination of Provider's eligibility and need for Provider's services. Dentegra may also, at its sole discretion, select or deselect individual Rendering Professionals based upon Dentegra's quality management program, as described in Section V page 5 of this Agreement. Dentegra shall notify Provider in writing of Provider's selection as a Participating Provider and when any Rendering Professional has been approved to treat Enrollees.

b. The carrier's quality assurance standards, which shall be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care criteria used to select and/or tier providers.

Dentegra promotes an understanding and awareness of access standards through communications to the dentist and enrollees. Dentegra records, tracks and responds to each categorized access grievance received according to regulatory expectations for Department of Insurance (DOI). Dentegra runs quarterly reports based on eligibility of PPO enrollment from the Health Care Exchange for the state of Colorado.

2. Network Standards and Adequacy
   a. The carrier's criteria for assessing network adequacy;

Geographic accessibility reports are available showing access from members to Dentegra PPO providers. The Access Standard is defined as members having access by geographic type, as defined by Colorado Department of Insurance (DOI):

Large Metro areas... 1 Dentegra PPO dentist in 15 miles

Metro areas... 1 Dentegra PPO dentist in 30 miles

Micro areas... 1 Dentegra PPO dentist in 60 miles

Rural areas... 1 Dentegra PPO dentist in 75 miles

CEAC areas... 1 Dentegra PPO dentist in 110 miles

   b. A statement verifying the carrier's adequate networks; and

As of June 2018, 100% of members meet the access standard. There are 556 General Dentists at 288 locations, with 98 single dentist locations and 190 multiple dentist locations.

Specialty dentists:

- **24 Pediatric Dentists at 36 locations**
- **31 Endodontists at 102 locations**
- **27 Oral Surgeons at 103 locations**
- **40 Orthodontists at 83 locations**
- **24 Periodontists at 80 locations**
- **2 Prosthodontists at 3 locations**

c. The carrier's description of specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers and policyholders, if a network is found to be inadequate.

Dentegra will monitor the dental office's policy for emergency contact and assure compliance with these access standards as required by governing regulatory bodies. Dentegra will provide feedback to dental offices that do not meet the access guidelines set by the Department of Insurance. Dentegra will also survey eligible enrollees about their satisfaction with Dentegra dentists, and include questions about appointment availability. Dentegra will follow-up with dentists on any issues reported to Dentegra by eligible enrollees. Dentegra will track and analyze grievances pertaining to access to identify potential access issues. Quarterly meetings are held by the Network Adequacy Committee to review any disparity between network and enrollment with the Professional Relations department. The focus is to review recruitment activity for resolution of access to care disclosures.

3. Network Monitoring and Corrective Action Processes
   a. The carrier's documented quantifiable and measureable process for monitoring and assuring the sufficiency of the network in order to meet the managed care needs of populations enrolled in dental managed care plans on an ongoing basis; and
   b. The carrier's process to assure that a covered person is able to obtain a covered benefit at the in-network level of benefit from a non-participating provider should the carrier's network prove to not be sufficient.

Network adequacy is reviewed by the Network Adequacy Monitoring Committee (NAMC). NAMC consists of:

- **Professional Relations Directors**
- **Professional Relations Managers**

- **Network Development Analysts**

NAMC meets quarterly to review and resolve network adequacy shortfalls. Each participant receives a monthly and quarterly report comparing dentist to enrollee ratios and make recommendations to resolve recruitment issues and concerns.

- **NAMC reports on previous network deficits and reviews what progress has been made to resolve these issues.**
- **NAMC will assist in resolving any grievances through the Healthcare Insurance Casework Systems (HICS).**
- **Current enrollment files are provided monthly from the Eligibility department.**
- **Geographical accessibility reports are generated monthly based on parameters defined for each state (mileage, provider make-up or both).**
- **The enrollment file and geographic report are reviewed and trends and network deficits are documented.**
- **Reports are also reviewed for gaps in the network based on predetermined state mileage/dentist ratio requirements for the service area of each state.**

A member may seek services from any Dentegra provider for any dental service. Prior authorizations are not a requirement of PPO plans administered by Dentegra. Enrollees may seek treatment from any Dentegra provider for any dental procedure without notifying Dentegra's PPO plan for prior approval. If the member cannot find a network provider, Customer Service can be reached at (877) 280-4204 and will assist the member in finding a non-network provider.

4. Referral Process
   a. A comprehensive listing, made available to covered persons and medical/dental providers, of the carrier's network participating providers;
   b. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a managed care plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers;
   c. A managed care plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to policyholders, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees;
   d. Timely referrals for access to specialty care;
   e. A process for expediting the referral process when indicated by the health condition;

f. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse;
g. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse; and
h. The carrier's process allowing covered persons to access services outside the network when necessary.

Referral of enrollee's out-of-network, including criteria for determining when an out-of-network referral is appropriate is not a requirement for Dentegra Insurance Company. As a Dentegra PPO enrollee, Dentegra PPO enrollees are free to visit any licensed dentist and still receive benefits. Lower out-of-pocket costs are likely when going to a Dentegra dentist.

A member may seek services from any Dentegra provider for any dental service. Prior authorizations are not a requirement of PPO plans administered by Dentegra. Enrollees may seek treatment from any Dentegra provider for any dental procedure without notifying Dentegra's PPO plan for prior approval. Enrollees and their dependents are free to seek treatment from any licensed dentist.

5. Communications
A carrier shall address its method for informing policyholders of the plan's services and features through disclosures and notices to policyholders in the network access plan for each network offered by the carrier.

Plan benefit books are provided to each individual with coverage outlining these processes. This is also available on the Dentegra web site for benefit information

6. Patients with Special Needs
The carrier's documented process to address the needs, including access and accessibility of services, of policyholders with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and/or mental disabilities.

The Dentegra Providers agree to the following:

(a) Treat Enrollees with the same quality and provide access to care consistent with the balance of Provider's practice and not differentiate or discriminate against any Enrollee on the basis of source of payment; and

(b) Not unlawfully differentiate or discriminate against an Enrollee, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, place of residence, physical handicap, medical condition, marital status, sexual orientation, age or sex; and

(c) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Public Law 103-227 (US. Pro-Children Act of 1994 [20 USC 6081, et. seq.] and Section 1352 of Title 31), United States Code regarding prohibitions against using federal funds for lobbying; and

(d) Not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicare or Medicaid under sections 1128 or 1128A of the Social Security Act, for the provision of dental services, utilization review, medical social work or administrative services; and

(e) Not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an advance directive (as advance directive is defined under federal law).

(f) Comply with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7. Grievance and Appeal Procedures
The carrier's grievance procedures, which shall be in conformance with Division rules concerning prompt investigation of claims involving utilization review and grievance procedures.

You may file a dispute in situations where Dentegra has had the opportunity to review all required supporting documentation. Please submit a written dispute (our form can be found in the Document Center in the For Providers section of dentegra.com) within 365 days of the action or inaction precipitating the grievance.

8. Coordination and Continuity of Care
Carriers shall ensure sufficient continuity of care provisions for their policyholders.
   a. A carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.
   b. Irrespective of whether it is for cause or without cause or due to non-renewal of a contract, the carrier shall make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information contained in regulation, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with this regulation. This notice shall be provided to all

covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous six (6) months.

c. A covered person shall have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.

d. A carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.

e. A carrier shall make available to the covered person a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier shall provide information about how the covered person may request continuity of care as required by this regulation.

f. A carrier's transition procedures shall provide that:
   (1) A carrier shall review requests for continuity of care made by the covered person or the covered person's authorized representative;
   (2) Requests for continuity of care shall be reviewed by the carrier's Medical/Dental Director after consultation with the treating provider. This requirement applies to:
      (a) Patients who meet the applicable criteria listed in this regulation; and
      (b) Who are under the care of a provider who has not been removed or leaving the network for cause;
   (3) The continuity of care period for covered persons what are undergoing an active course of treatment shall extend to the earlier of:
      (a) The termination of the course of treatment by the covered person or the treating provider;
      (b) Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical/Dental Director determines that a longer period is necessary;
      (c) The date that care is successfully transitioned to a participating provider;
      (d) Benefit limitations under the plan are met or exceeded;
      (e) The date that the coverage is terminated; or
      (f) The care is no longer medically necessary.

g. In addition to the provisions of item 8 of Appendix B of this regulation, a continuity of care request may only be granted when the provider departing or terminated from the network:
   (1) Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the carrier for that patient as provider in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier; and
   (2) Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

h. The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.

Providers have agreed to giving Dentegra ninety (90) days written notice of termination, subject to the provisions of our Provider Agreement.

In the event of notice of termination of this Agreement or a Program, Provider shall continue to schedule and honor existing appointments of Enrollees until the effective date of termination. As of the effective date of termination of this Agreement or a Program, the provisions of this Agreement shall be considered of no further force or effect whatsoever and each of the parties shall be relieved and discharged here from, except that:

(a) Termination shall not affect any rights or obligations that have previously accrued or shall thereafter arise with respect to any occurrence prior to the effective date of termination and any such rights and obligations shall continue to be governed by the terms of this Agreement;

(b) Unless Dentegra makes other reasonable and medically appropriate provision for the performance of services, Provider shall complete all dental services begun (but not completed) prior to termination.

(c) Provider agrees to specifically notify all Enrollees that the Provider is no longer contracted to render services as a Participating Provider.

Participating dentists are contractually held to notify their patients if they no longer participate with Dentegra Insurance Company. In the Provider Agreement, Section VI, page 5: Records and Availability for Inspection states:

Access to Dental Records: Subject to compliance with applicable federal and state laws and professional standards regarding the confidentiality of patient records, Provider shall assist Dentegra in achieving continuity of care for Enrollees through the maximum sharing of patient records for services rendered to Enrollees. Provider's obligations under this Paragraph shall include, without limitation:

(a) Providing Dentegra with copies of Enrollee patient records that are in the custody of Provider or any Rendering Professional;

(b) Allowing Dentegra authorized personnel, its designated representatives, accreditation and review organizations and government agencies access to such records on Provider's premises during regular business hours;

(c) Upon reasonable request, providing copies of an Enrollee's patient records to any other Participating Provider treating such Enrollee.

In the event of notice of termination of this Agreement or a Program, Provider shall continue to schedule and honor existing appointments of Enrollees until the effective date of termination. As of the effective date of termination of this Agreement or a Program, the provisions of this Agreement shall be considered of no further force or effect whatsoever and each of the parties shall be relieved and discharged here from, except that:

a. Termination shall not affect any rights or obligations that have previously accrued or shall thereafter arise with respect to any occurrence prior to the effective date of termination and any such rights and obligations shall continue to be governed by the terms of this Agreement;

b. Unless Dentegra makes other reasonable and medically appropriate provision for the performance of services, Provider shall complete all dental services begun (but not completed) prior to termination.

c. Provider agrees to specifically notify all Enrollees that the Provider is no longer contracted to render services as a participating Provider.