Delta Dental Plan of Michigan

Delta Dental PPO™ Network & Delta Dental Premier® Network Access Plan Colorado

Provider Access & Availability Standards:

Delta Dental is committed to offering unparalleled depth and quality in its provider networks which offer a broad choice of dentists to ensure all services will be accessible without unreasonable delay to its subscribers. Delta Dental utilizes feedback from subscribers, groups, and carriers who request that specific providers join the network by actively engaging with those providers as part of its recruiting efforts. Members that see a provider in the state of Colorado will be utilizing a participating provider that is credentialed by Delta Dental of Colorado. Additionally, Delta Dental does annually review Delta Dental of Colorado's network provider credentialing and re-credentialing policies and procedures to make sure the network is in compliance with Colorado standards. Delta Dental PPO & Delta Dental Premier network encompass the whole of the Delta Dental network of providers.

Delta Dental has adopted the following general accessibility standards for both general dentists and specialists:

- Urban – 1dentist within 15 miles
- Suburban – 1dentist within 30 miles
- Rural – 1 dentist within 45 miles

Delta Dental has adopted the following general availability standards state-wide (dentists: members):

- General Dentists 1 dentist:2,000 covered members
- Specialists 1 dentist: 6,000 covered members

Delta Dental uses the GeoAccess software to run provider accessibility and availability within a geographic region. This application allows Delta Dental to determine the number of providers, by area of practice and geographic segment. With this data, we are able to run provider lists, maps and other visual presentations of the network for our clients.

These standards strive to ensure an appropriate number and type of dentists are available to covered members and their eligible dependents, and all services will be accessible without unreasonable delay. Delta Dental conducts continual network recruitment, and accepts all dental providers who pass the rigors of the credentialing process. In the event that covered membership increases in a certain geographic area, Delta Dental shall conduct a targeted recruitment to provide its covered members with adequate access to care. Both participating and non-

participating providers receive printed news bulletins from Delta Dental periodically to provide valuable claims processing information, as well as details on a variety of current topics of interest for the dental profession. This helps all dentists become familiar with Delta's programs and procedures.

Colorado State Specific Provider Access & Availability Standards

At least one dental provider and facility is available within the maximum road travel distances listed below, of any enrollee in each specific carrier's network.

The plan will provide access to at least one dental provider for at least 90% of the enrollees.

Geographic Type	Maximum Road Travel Distance
Large Metro	15 miles
Metro	30 miles
Micro	60 miles
Rural	75 miles
Counties with Extreme Access Considerations	110 miles

Ongoing Monitoring Process:

The network is expected to take into consideration any change in population for a given area. If there is a significant change in covered members for a given area in the state, a targeted recruitment will take place there. Each year a strategic recruitment plan is developed to address the needs of evolving member populations.

The network recruitment and retention process is ongoing, and dentists are only involuntarily terminated for cause (i.e., inability to maintain a license, disbarment from governmental program, numerous quality complaints, ongoing patterns of fraudulent activity, etc.), provided they pass the credentialing or recredentialing process. Additionally, Delta Dental annually reviews Delta Dental of Colorado's network access and availability standards to make sure our networks are in compliance with Colorado standards.

As stated in the Processing Out-of-Network claims section, if an In-Network Dentist is not readily available within a reasonable period of time or driving distance, it may be possible to receive covered services from an Out-of-Network Dentist and be reimbursed at the same benefit level as if provided by an In-Network Dentist. If you feel this may be the case, please call Delta Dental's

customer services department, toll free at [(888) 791-5995 (TTY users call 711) for individual dental members, or (800) 894-4532 (TTY users call 711) for employer-sponsored group plans] or write to us at [P.O. Box 1596, Indianapolis, Indiana 46206]. We will review your situation and, if appropriate, authorize payment for covered service provided by a non-participating providerat the participating provider benefit level.

Corrective Action

Delta Dental uses the GeoAccess software to run provider accessibility and availability within a geographic region. This application allows Delta Dental to determine the number of providers, by area of practice and geographic segment. With this data, we are able to run provider lists, maps and other visual presentations of the network for our clients.

These standards strive to ensure an appropriate number and type of dentists are available to covered members and their eligible dependents, and all services will be accessible without unreasonable delay.

If our dental network is ever found to be inadequate, Delta Dental will promptly work with our network partners to ensure compliance with the laws and regulations of Colorado.

In the event that insufficient network adequacy is identified or the lack of Essential Community Providers or Indian Health Care Providers, action will be taken to try to improve provider participation in the identified area.

Use of Telehealth

Where medically appropriate, Delta Dental provides coverage for dental services provided by means of telehealth. If a service is covered when provided in-person, it will be covered when performed via telehealth, to the extent medically appropriate. Telehealth services may be covered when provided by either participating or non-participating providers.

Plan for Addressing the Needs of Special Populations:

When a covered member calls the toll-free Delta Dental customer service number and requires translation services, the covered member has the option to have the call transferred to a contracted translator to help answer any questions or concerns posed by the covered member, in his or her own language. Delta Dental has established the Language Assistance Program in order to make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided Auxiliary aids and services or Language assistance services.

Auxiliary aids and services include, but are not limited to, the following:

- Qualified interpreters on-site or through video remote interpretation, note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, telephones compatible with hearing aids; etc.
- Qualified readers, taped texts, audio recordings, Braille materials and displays, screen reader software, magnification software, etc.
- Qualified sign language interpreter, large print materials, Text telephone (TTY), Captioning, Screen reader software, video remote interpreting services.

Language assistive services include, but are not limited to, the following:

- Oral language assistance, including interpretation in non-English languages provided in person or remotely by a qualified interpreter;
- Written translation, performed by a qualified translator of written content in paper or electronic form;
- Taglines.

Covered members have the option of requesting a significant document concerning benefit information in a language other than English free of charge.

In the event Delta Dental becomes aware of certain service areas that are predominately non-English or special needs, Delta Dental will contact its networks and request targeted recruitment to provide an appropriate number and/or types of dentists available for the given population.

Delta Dental is committed to meeting the needs of all individuals, including those with physical or mental disabilities. Delta Dental offers the AT&T National Relay Service for all hearing-impaired covered members. The 711 Relay Service provides toll free telephone accessibility for people who are deaf, hard of hearing or speech impaired and is available 24 hours a day, 365 days a year. Specially trained Communication Assistants connect the call and remain on the line to assist in the conversation. In addition, our customer service representatives will work with persons who have other types of disabilities and provide individualized attention to make sure they received the care and coverage they used. Finally, our Delta Dental network of dental providers is committed to providing care to persons without regard to disability. If a dentist doesn't have the skills, knowledge, equipment or expertise to treat a person with a particular type of disability, then they should refer that patient to a dentist who can provide the appropriate care.

Processing Out-of-Network Claims

If a covered member requires emergency treatment and receives covered services from a non-participating provider, covered services for the emergency care rendered during the course of the emergency will be treated as if they had been provided by a participating provider had provided them. Also, if a covered member receives covered services that are not of the type provided by any participating provider or are not readily available from a participating provider within a reasonable

period of time or driving distance, the covered services will be treated as if they had been provided by a participating provider. If a participating provider is readily available both in respect to waiting time and driving distance, it would be inappropriate for a covered member to receive covered services at a participating provider benefit level for covered services rendered by a non-participating provider.

If a covered member feels like either of the above circumstances applies they may contact our Customer Service Department at 1-888-791-5995 (TTY users call 711) for individual dental members, or (800) 894-4532 (TTY users call 711) for employer-sponsored group plans. Delta Dental will review the covered member's situation and, if appropriate, authorize payment for a non-participating provider at the participating provider benefit level. A customer service representative will follow up with the covered member within 3 business days to confirm whether the covered member is entitled to have their claim process as if the services were provided by a participating provider.

Subscriber Communication Methods:

Upon enrollment, each Delta Dental subscriber is issued a policy or certificate (depending on whether they have enrolled in a group dental product or an individual dental product) along with a summary of benefits. The policy or certificate will be mailed directly to the subscriber of an individual dental plan and either directly to the employer for distribution for a group dental plan or, at the direction of the group, directly to the employee. The policy or certificate describe in detail the dental plan's benefits, annual maximums, co-payments, co-insurance, grievance procedures, process for choosing and changing providers, and its procedures for providing benefits in the event of an emergency situation. For example, a covered member is encouraged to seek treatment from a participating provider in order to receive the maximum dental benefits and reduce any out-of-pocket costs. However, if a covered member requires emergency treatment (or in some instances does not have access to a participating provider) and receives covered services from a non-participating provider, the covered services received by the non-participating provider during the course of the emergency will be treated as if they had been provided by a participating provider. The benefits of using aparticipating provider compared to a non-participating provider are illustrated in the summary document given to all subscribers.

Where required by state law, Delta Dental will provide written notice to subscribers in situations where a participating provider is being removed, leaving the network or is being non-renewed. This written notice must be provided to all subscribers who are identified as patients by the provider, are on the Delta Dental patient list for that provider, or have been seen by that provider within the previous 6 months.

Continuity of Care:

Delta Dental updates its searchable provider database on a nightly basis to reflect the current participation status of all providers in its networks. Subscribers shall be notified in the manner provided in the Subscriber Communication Methods section above, when their provider's participation with the network is ending. Delta Dental shall take reasonable steps to transition covered members in an active course of treatment to another participating provider in a manner that facilitates continuity of care. Delta Dental shall provide listings of other participating providers who are accepting new patients by way of its provider directory. For help with continuity of care concerns, covered members may call customer service for group plans at (800) 894-4532 or individual plans at 888-791-5995.

Covered members are free to transfer to a new provider or remain with their current provider in the event their provider no longer participates with our networks, according to the terms and requirements of the covered member's insurance policy, certificate, or equivalent document. Since Delta Dental has one of the nation's most robust dental networks, it should not be difficult for most covered members to find another participating provider within a reasonable distance from their residence.
When Delta Dental contracts with providers to become part any of its networks, they agree to abide by the applicable participation agreement, which includes a specific hold harmless provision that prohibits balance billing the patient in the event of Delta's insolvency or inability to continue operations. Delta Dental does not require referrals or prior authorizations for any covered services.

Provider Directory:

If a Delta Dental member would like to review or access a list of Delta's providers they may do so online through Delta's website at **www.deltadental.com**. The member can select "Patient, then "Find a Provider" and be provided with a list of participating providers.

If the member prefers to have access to a hard copy of the provider directory, they may print the online directory, which is updated on a nightly basis. The member may also contact Delta Dental's customer service department to be provided with a copy of the current provider directory to print. The customer service phone number members can call is (800) 524-0149. A member may also request a hard copy of the provider directory by mailing Delta Dental at:

Delta Dental
P.O. Box 9098
Farmington Hills, MI 48333

Appeals and Grievances:

As more specifically set forth in the policy or certificate, the subscriber ("you") shall have the rights and responsibilities set forth in this section as it relates to Appeals and Grievances.

Utilization Review

Delta Dental performs only retrospective, post-service dental utilization review and determinations. Delta Dental does not issue pre-authorizations, perform prospective utilization review, or render pre-treatment utilization review determinations.

For retrospective review determinations, Delta Dental shall make the determination and notify you of the determination within 30 calendar days after receiving your benefit request. The time period for making a determination and notifying you of the determination may be extended for up to 15 calendar days if necessary due to matters beyond Delta Dental's control, and if Delta Dental notifies you prior to the expiration of

the initial 30-day time period of the circumstances requiring the extension and the date by which Delta Dental expects to make the determination. If the extension is due to your failure to submit information necessary to reach a determination, the notice of extension will describe the information necessary to complete the request, and will give you 30 calendar days to provide the information.

Claims Appeal Procedure

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefits for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefits you sought ("Adverse Benefit Determination").

This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

If Delta Dental informs you that the policy will pay the benefits you sought but will not pay the total amount of expenses incurred, and you must make a payment to satisfy the balance, you may also treat that as an Adverse Benefit Determination.

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps: First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, [1-888-791-5995 (TTY users call 711) for individual dental members, or (800) 894-4532 (TTY users call 711) for employer-sponsored group plans], and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service Department at [P.O. Box 1596, Indianapolis, Indiana 46206]. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Whether or not you have asked Delta Dental informally, as described above, to recheck our initial determination, you can submit your claim to a formal review through the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.
To request a formal review of your claim, send your request in writing to:

Dental Director
Delta Dental Plan of Michigan, Inc.
[P.O. Box 30416
Lansing, MI 48909-7916]

Please include your name and address, the subscriber's Member ID number, the reason you believe your claim was wrongly denied, any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. If you are requesting review of a benefit denial due to a contractual exclusion, you must provide evidence from a licensed medical professional that there is a reasonable medical basis that the exclusion does not apply. You have the right to review any documents related to the Policy. If you would like a record of your request and proof that Delta Dental received it, you should mail it certified mail, return receipt requested.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination. If Delta Dental considers, relies upon, or generates any new or additional evidence or rationale(s), suchwill be provided to you sufficiently in advance of the final internal Adverse Benefit Determination to give you a reasonable opportunity to respond.

For reviews involving an Adverse Benefit Determination based on utilization review, or involving a benefit denial based on a contractual exclusion for which you provide evidence from a licensed medical professional that there is a reasonable medical basis that the exclusion does not apply, you shall be provided with a choice between a written appeal or a review meeting.

If you choose a written appeal: (1) You are entitled to submit written comments, documents, records, and other material for the reviewer(s) to consider; (2) You are entitled to receive from Delta Dental, free upon request, reasonable access to and copies of all documents, records, and other information relevant to your requested review; (3) You are not entitled to be present at the review.

If you choose a review meeting: (1) You have the right to appear in person or by telephone conference; (2) You have the right to bring counsel, advocates and health care professionals to the review meeting; (3) The review meeting will be held within 60 days of Delta Dental’s receipt of your request for a review meeting; (4) You will be notified at least 20 days in advance of the meeting date, and the notice will include the following: (a) Your right to present written comments, documents, records, and other material for the reviewer(s) to consider both before and at the review meeting; (b) Your right to receive, upon request, a copy of the materials that Delta Dental intends to present at the review meeting at least 5 calendar days before the review meeting; (c) Your responsibility to submit a copy of materials you plan to present or have presented on your behalf at the review meeting to Delta Dental at least 5 calendar days before

the review meeting; (d) Your responsibility to, within 7 calendar days before the review meeting, inform Delta Dental whether you intend to have an attorney present to represent your interests; (e) Indication of whether Delta Dental intends to have an attorney present at the review meeting to represent its interests; (f) Indication that Delta Dental will make an audio or video recording of the review meeting, unless neither party wants the recording made. If a recording is made, it will be made available to you and, if there is an external review, will be provided to the external review entity unless you request it not be provided. Your Dentist may communicate directly with the Dentist involved in the initial Adverse Determination.

The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Your notice of an Adverse Benefit Determination will inform you of the following: Information to identify the claim involved, and a statement describing the availability, upon request, of the diagnosis code and treatment code, and their meanings. The name, title, and credentials of the reviewer(s); a statement of the reviewer(s) understanding of your request for review; the reviewer(s) decision; a reference to the evidence or documentation used as the basis for the decision; the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, or an experimental or investigational or similar treatment exclusion, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

Questions regarding your policy or coverage should be directed to: Delta Dental by (a) writing

Delta Dental
Attention: Customer Service
P.O. Box 30416

Lansing, MI 48909-7916
or (b) calling the toll-free number, 1-888-791-5995 (TTY users call 711) for individual dental members, or (800) 894-4532 (TTY users call 711) for employer-sponsored group plans.

Colorado residents please note: If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Colorado Department of Regulatory Agencies, Division of Insurance by mail, telephone or email: 1560 Broadway, Suite 850, Denver, CO 80202. Consumer Hotline: 303-894-7499 Complaints can be filed electronically at https://doi.colorado.gov.