# ACCESS PLAN – COVER SHEET

## Golden Rule Insurance Company
## HIOS ID 59036, UnitedHealthcare of Colorado, Inc.
## Dental Benefits Providers, Inc. (DBP) PPO = Dent001

The DBP dental PPO network gives members the freedom to use any dentist in our national network. Members do not need to choose a primary dentist and members do not need a referral to see a specialist.

### Required Access Plan Elements

1. Standards for network composition:

Describe how the issuer establishes standards for the composition of its network to ensure that networks are sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay. Standards must be specific, quantifiable, and measurable based on the anticipated needs of their membership. Common approaches include provider-to-enrollee ratios and time and distance standards. Issuers must also document that their proposed network meets these standards.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented process to establish standards for network composition? | Yes | Page 5 |
| Does the issuer's standard address how the network will be sufficient in number and type of providers? | Yes | Page 5 |
| Is the issuer's standard quantifiable and measurable? | Yes | Page 5 |
| Does the issuer provide documentation or evidence that its proposed network meets its standard? | Yes | Page 5 |

2. Referral policy:

Describe the issuer's procedures for making referrals within and outside of its network.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented process for making referrals inside and outside the network? | Yes | Pages 5-6 |
| Does the process allow members to access services outside the network when necessary? | Yes | Pages 5-6 |

3. Ongoing monitoring:

| Describe the issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of the population enrolled.<br>Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented process for monitoring, on an ongoing basis, the sufficiency of the network to meet the needs of its members? | Yes | Pages 6-7 |
| Does the issuer include a both quantifiable and measurable approach to monitoring ongoing sufficiency of its network? | Yes | Pages 6-7 |

4. Needs of special populations:

Describe the issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented process to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities? | Yes | Page 7 |
| Does the issuer's process identify the potential needs of special populations? | Yes | Page 7 |
| Does the issuer's response describe how its process supports access and accessibility of services for special populations? | Yes | Page 7 |

5. Health needs assessment:

Describe the issuer's methods for assessing the needs of covered persons and their satisfaction with services.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented method for assessing the needs of covered persons? | Yes | Pages 7-8 |
| Does the proposed method include a review of quantitative information? | Yes | Pages 7-8 |
| Does the proposed method assess needs on an ongoing basis? | Yes | Pages 7-8 |
| Does the proposed method assess the needs of diverse populations? | Yes | Pages 7-8 |

6. Communication with members:

Describe the issuer's method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care? | Yes | Page 7 |
| Does the method address the process for choosing or changing providers and access to emergency or specialty services? | Yes | Pages 5-6, 9 |
| Does the process describe how it supports member access to care? | Yes | Page 9 |

7. Coordination activities:

Describe the issuer's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented process for ensuring coordination and continuity of care? | Yes | Page 9 |
| Does the proposed process address specialty care referrals; ancillary services, including social services and community resources; and discharge planning? | Yes | N/A for routine dental |
| Does the response describe how the process supports member access to care? | Yes | Page 7 |

8. Continuity of care:

Describe the issuer's proposed plan for providing continuity of care in the event of contract termination between the health issuer and any of its participating providers or in the event of the issuer's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, issuer's insolvency, or other cessation of operations and how they will be transferred to other providers in a timely manner.

| Evaluation criteria | Included in Access Plan | Page number for Supporting documentation |
|---|---|---|
| Does the issuer have a documented plan for ensuring continuity of care? | Yes | Page 9 |
| Does the issuer have a "hold harmless" prodental in its provider contracts, prohibiting contracting providers from balance-billing enrollees in the event of the issuer's insolvency or other inability to continue operations? | Yes | Page 9 |

# Golden Rule Insurance Company
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# Dental Benefits Providers, Inc. (DBP) PPO = Vis001

## Standards for Network Composition

We have specific, quantifiable standards for numeric (provider to member ratios) and geographic (distance) availability of participating providers and practitioners. The network composition is measured against these standards at least annually to ensure the network is sufficient in number and type of practitioner to ensure services are accessible without unreasonable delay. An analysis of the network is also conducted as to how well the network meets member needs and cultural preferences.

**Dental Services Results and Analysis:** Our current ratios for the network of providers serving our membership was reviewed and determined to be adequate in each county or within a reasonable driving distance as defined by county designation time/distance specifications. To serve these members we have 1656 optometrists and 97 ophthalmologists.

The provider-to-member ratio for all dental providers is 1:10 in urban areas, 1:15 in suburban areas, and 1:20 in rural areas.

Telemedicine and Telehealth services, services where the dental provider or professional and the patient are not located at the same site, are covered expenses. This policy applies to all products and all network and non-network providers and other qualified dental professionals. Examples of such services are those that are delivered over the phone, via the internet or using other communication devices.

## Referral Policy

Referrals are not required for this plan.

**Out-of-Network Requests and Continuing Care:** If a member is unable to find an in-network provider due to distance and/or appointment scheduling, they may contact Customer Service who will confirm there is not an in-network provider within reasonable distance or appointment availability and document on the member's record. The member is then instructed on how to submit their claim which will be reimbursed at the in-network benefit. The Out of Network claim form with instruction can be found at myuhc.com.

The provider agrees that in the event this Agreement is terminated by DBP without cause and proper notice has not been provided to Enrollees, the Provider shall continue the pro dental of Covered Services to Enrollees for sixty (60) days from the date the Provider is terminated by DBP.

It is stated in the provider's agreement that they must give a minimum of 90 days notice of intent to terminate and further states they must complete any services in progress and allow member time to transfer their record to another network provider. In the event of carrier insolvency, we would notify all members in writing via the US Postal Service.

Procedures covering both situations are documented in the policy titled "Out of Network Requests and Continuing Care". The purpose of the process is to provide timely and consistent determinations and notices for all out of network coverage requests and to ensure members have needed information regarding alternatives for continuing care. Examples of Out of Network Coverage Requests include the following:

- **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.
- **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly member who is receiving ongoing care a transition period before they are required to transfer from an out-of-network provider to an in-network provider and to receive network benefits under the terms of the employer health benefits or government program contract for the transition period.
- **Continuity of Care (CoC):** A request for CoC is based on a benefit which allows a member to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The member is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider under the terms of the employer health benefits or government program contract.

## On-Going Monitoring:

Annually, DBP completes a network adequacy assessment to identify improvement to members' access to services. Included in the network adequacy assessment are evaluation of availability (geographic, numeric, cultural and linguistic availability of practitioners), accessibility (access to appointments). Vision plan data is collected from member surveys, and member experience for routine and urgent care. An assessment of complaints and appeals related to access to care is integrated into the analysis. Requests for out-of-network utilization of services are also included in the analysis.

The results of this annual assessment identify high priority opportunities and help develop a dental network implementation plan intent on improving member access to dental provider services for the next annual assessment.

DBP maintains standards for the numeric and geographic availability of participating practitioners and providers. DBP analyzes the networks against these established standards at least annually. At least biennially, DBP assesses how well the network meets members' cultural needs and preferences. Interventions related to both analyses are identified and implemented to improve availability when needed. Assessments are conducted in accordance with state, federal and regulatory requirements.

In the event of dental network inadequacy:

DBP is committed to continuous searching for additional dental providers entering the market for viable candidates. If additional providers are identified locally and determined to be viable candidates, DBP contacts those providers to determine their interest in network participation.

DBP negotiates rates for treatment with any available out-of-network provider for members without access on a case by

case basis to ensure that members are held harmless from balance billing for amounts over the plan's in-network contracted copayments, deductibles, or coinsurance percentage.

DBP's website and customer service will assist members with locating dental providers.

A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.

## Needs of Special Populations:

The Health Equity Services (HES) program was established to help address health disparities. The HES program helps reduce health disparities by improving our culturally sensitive initiatives that promote health and prevent avoidable health care cost. To accomplish this, the HES program operates with four key focus areas:

- Collecting data to better understand our membership and their cultural characteristics
- Identifying gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language
- Growing multicultural capabilities to enhance the member experience

We continue to significantly enhance our HES programs and offerings through:

- Employee training for more insight about providing services to our members from diverse cultural backgrounds
- Customized member outreach and communication
- Enhanced data analytics to address identified health disparities

The Health Equity Services program completed an enterprise compliance assessment of the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and is at industry standard or better for all 15 standards. Despite being at industry standard or better for all CLAS standards, we continue to plan and implement improvements that will further our efforts to reduce identified member health outcome disparities.

Evaluation of members' cultural, ethnic, racial and linguistic needs may be measured using the following data sources:

- CAHPS® data
- Member Satisfaction Survey Data
- U.S. Census Data
  - Network Database (NDB)
  - Enrollment Data
  - Medicare/Medicaid eligibility files
  - Focus Groups
  - American Community survey
  - Other Sources As Required Or Needed

To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability.

## Health Needs Assessment:

Our policy is to assess member experience with its services and programs, at least annually, and identify areas for potential improvement. When opportunities for improvement are identified, actions are taken to improve member experience.

Primary data collection sources include member complaints and appeals, UM consumer concerns, and member experience surveys. Member experience surveys may include, but are not limited to:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS®)
- Key Member Indicators (KMI) Survey
- Member Focus Groups
- Complex Case Management Surveys
- Disease Management Surveys
- State, Federal and Regulatory Surveys

### TeleHealth

"Telehealth" means a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies to facilitate the assessment, diagnosis, consultation, treatment, education, care management or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. This term includes;
(A) Synchronous interactions
(B) Store-and-forward transfers and
(C) Services provided through HIPAA compliant interactive audio-visual communication or the use of a HIPAA compliant application via a cellular telephone

Telehealth" does not include delivery of health care services via:
Voice-only telephone communication or text messaging;
(A) Facsimile machine; or
(B) Electronic mail systems
(C) Electronic mail systems.

## Communication with Members:

It is our policy to ensure that members have access to information regarding key topics about their benefits and plan design including but not limited to:

- Member rights and responsibilities,
- Accessing Customer Care,
- Voicing complaints and grievances,
- Choosing and changing primary care physicians,
- Accessing routine, specialty and emergency care, and
- Understanding benefit coverage exclusions, restrictions and notifications.

Procedures for communicating with members are outlined in the policy titled "Member Communication". Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide and the annual Rights and Resource Disclosure Booklet. Members also have access to myuhc.com, a website with resources for accessing personal health records, finding physicians, and encouraging healthy behaviors.

The dental directory is located on myuhc.com. The directory is accessible without a username and/or password. The on-line directory information is updated daily. Providers may submit their practice information directly on the provider portal. Dental Benefit Providers strives to meet the needs of patients with communication differences by providing a toll-free number for language assistance that will help the enrollee communicate with us. Such as letters in other languages or large print.

## Continuity of Care:

The provider agrees that in the event this Agreement is terminated by DBP without cause and proper notice has not been provided to Enrollees, the Provider shall continue the provision of Covered Services to Enrollees for sixty (60) days from the date the Provider is terminated by DBP.

It is stated in the provider's agreement that they must give a minimum of 90 day's notice of intent to terminate and further states they must complete any services in progress and allow member time to transfer their record to another network provider. In the event of carrier insolvency, we would notify all members in writing via the US Postal Service.