Renaissance Life & Health Insurance Company of America

Network Access Plan
Colorado

Network Composition Standards:

Renaissance is committed to offering a robust provider network that maximizes the number of dentists available to ensure all covered services will be accessible without unreasonable delay to its subscribers and their eligible dependents (collectively "covered members"). Renaissance uses software to run provider accessibility and availability mapping within a geographic region. This permits a determination of the number of providers by area of practice and geographic segment (city, county, etc.) and a corresponding visual representation of this distribution, which identifies where further targeted provider recruitment may be necessary. In addition, Renaissance entertains input from subscribers, groups, and carriers who request that certain providers be added to the network or require a targeted recruitment.

Renaissance's networks have independent criteria and processes in place to properly credential participating providers. Renaissance's networks are required to certify their sufficiency, including time and distance standards and provider-to-enrollee ratios, by comparing the Renaissance covered membership for all areas to the participating provider's location and specialty. Additionally, Renaissance does annually review our network's provider credentialing and re-credentialing policies and procedures to make sure our networks are in compliance with Colorado standards.

The accessibility standards for the Renaissance networks are the following for both general dentists and specialists:

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

The availability standards for the Renaissance networks are the following state-wide (dentists: members):

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

The standards above ensure a sufficient number and type of dentists are available to covered members and all services will be accessible without unreasonable delay. Renaissance's networks conduct continual network recruitment and accept all dental providers who pass the rigors of the credentialing process. In the event that covered membership increases in a certain area, Renaissance shall request its networks conduct a targeted recruitment to provide its covered members with adequate access to care.

Renaissance periodically runs reports (described in Ongoing Monitoring Process below) to identify the number of participating dentists within a state, as well as comparing its networks against other networks in a given geographic area. Review and analysis of these reports assists Renaissance with determining further recruitment needs. Additionally, several states have their own annual regulatory filings, certifying network composition and adequacy, and Renaissance files these in a timely manner as required.

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:

As mentioned above, Renaissance's networks are required to certify their sufficiency, including time and distance standards and provider-to-enrollee ratios, by comparing the Renaissance covered membership for all areas to the participating provider's location and specialty. Each 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, a targeted recruitment will take place there. Additionally, Renaissance does annually review our network's access and availability standards to make sure our networks are in compliance with Colorado standards.

Network recruitment is perpetual and dentists are only involuntarily terminated for cause (i.e., inability to maintain a license, disbarment from governmental program, numerous quality complaints, patterns of fraudulent activity, etc.), provided they pass the credentialing or recredentialing process. Software programs are used to generate reports continuously to confirm network adequacy.

Additionally, 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 RLHICA's customer services department, toll free at [(888) 791-5995 (TTY users call 711)] or write to us at [P.O. Box 1596, Indianapolis, Indiana 46206]. We will review your situation and, if appropriate, authorize payment for an Out-of-Network Dentist at the In-Network Dentist benefit level.

Corrective Action

Renaissance periodically runs reports (described in Ongoing Monitoring Process) to identify the number of participating dentists within a state, as well as comparing its networks against other networks in a given geographic area. Review and analysis of these reports assists Renaissance with determining further recruitment needs. Additionally, several states have their own annual regulatory filings, certifying network composition and adequacy, and Renaissance files these in a timely manner as required.

If a network is ever found to be inadequate Renaissance will promptly work with the network to get that network back into compliance with the laws and regulations of Colorado.

In the event that insufficient network adequacy is identified including 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

Renaissance does not currently utilize telehealth services in their networks.

Plan for Addressing the Needs of Special Populations:

When a covered member calls the Renaissance customer service number, the covered member immediately has the option to have the call transferred to a customer service representative who will immediately contact a contracted translator to help answer any questions or concerns posed by the covered member. Renaissance 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 Renaissance becomes aware of certain service areas that are predominately non-English or special needs, Renaissance will contact its networks and require targeted recruitment to provide the appropriate number of type of dentists for the given population.

Further, Renaissance 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.

Processing Out-of-Network Claims:

If a member requires emergency treatment and received covered services from non-participating provided, covered services for the emergency care rendered during the course of the emergency will be treated as if a participating provided had provided them. Also, if a 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 member to receive covered services at an In-Network cost from a non-participating provider.

If a 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). Renaissance will review the 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 member within 3 business days to confirm whether the member is entitled to have their claim process as if the services were provided by a participating provider.

Member Communication Methods:

Upon enrollment, each Renaissance subscriber will be 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 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 an in-network 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 an in-network provider) and receives covered services from an out-of-network provider, the covered services rendered by the out-of- network provider during the course of treatment will be treated as if they had been provided by an in-network provider. The benefits of using an in-network provider compared to an out-of-network provider are illustrated in the summary document given to all subscribers.

Where required by state law, Renaissance will provide written notice to subscribers in situations where an in-network 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 Renaissance patient list for that provider, or have been seen by that provider within the previous 6 months.

Continuity of Care:

Renaissance updates, no less frequently than monthly, its websites which list the dentists participating in each of its networks. Subscribers shall be notified in the manner provided in the Member Communication Methods section above, when their provider's participation with the network is ending. Renaissance shall take reasonable steps to transition covered persons in an active course of treatment to another participating provider in a manner that facilitates continuity of care. Renaissance shall provide listings of other participating providers who are accepting new patients by way of its provider directory.

Covered members are free to transfer to a new provider or remain with their current provider in the event he or she no longer participates with a network, according to the terms and requirements of the covered member's insurance policy, certificate, or equivalent document. Since Renaissance utilizes several third-party networks with a broad range of providers nationwide, it is not difficult for most covered members to find another participating provider within a reasonable distance from their residence.

All of the networks with which Renaissance contracts have language in their provider contracts which prohibits providers from balance billing patients under any circumstances. Renaissance does not require referrals or prior authorization for any covered services.

Provider Directory:

Renaissance updates their online provider directory every week. The online provider directory provides insureds the ability to print the most current version of a hard copy of the provider directory. Additionally, if an insured contacts Renaissance about obtaining a hard copy of the current provider directory, Renaissance will provide one to them.

The customer service phone number members can call is (888) 791-5995 for individual plans and (888) 358-9484 for group plans. A member may also request a hard copy of the provider directory by mailing Renaissance at:

Renaissance
P.O. Box 1596
Indianapolis, IN 46206-1596

Appeals and Grievances:

<u>Utilization Review</u>

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

For retrospective review determinations, Renaissance 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 Renaissance's control, and if Renaissance notifies you prior to the expiration of the initial 30-day time period of the circumstances requiring the extension and the date by which Renaissance 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

Renaissance 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 Benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the Benefit 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 Renaissance informs you that the Policy will pay the Benefit 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 Renaissance incorrectly denied all or part of your claim, you can take the following steps: First, you or your Dentist should contact Renaissance's Customer Service department at their toll-free number, [(800) 971-4108], 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. Renaissance provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Renaissance to correct this error quickly.

Whether or not you have asked Renaissance 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
Renaissance Dental - RLHICA
P.O. Box 1596
Indianapolis, IN 46206

Please include your name and address, the Insured'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 Renaissance 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 Renaissance considers, relies upon, or generates any new or additional evidence or rationale(s), such will 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 Renaissance, 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 Renaissance'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 Renaissance 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 Renaissance at least 5 calendar days before the review meeting; (d) Your responsibility to, within 7 calendar days before the review meeting, inform Renaissance whether you intend to have an attorney present to represent your interests; (e) Indication of whether Renaissance intends to have an attorney present at the review meeting to represent its interests; (f) Indication that Renaissance 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: Renaissance by (a) writing

Renaissance
Attention: Customer Service
P.O. Box 1596, Indianapolis
Indiana 46206,
or (b) calling the toll-free number, 800-971-4108.

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 www.dora.state.co.us.