Ameritas
fulfilling life

Ameritas Life Insurance Corp.

DENTAL SELECT PLATINUM NETWORK ACCESS PLAN

COLORADO

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Network Composition

Dental Select, a subsidiary of Ameritas Life Insurance Corp., is a licensed third-party administrator and insurance agency offering a network of leased dental providers in the Platinum Network. Dental Select's leasing partner contracts with and credentials the following types of dentists:

- General Dentists, Endodontists, Oral Surgeons, Orthodontists, Pediatric Dentists, Periodontists, and Prosthodontists.

General dentists, who are trained in all aspects of dental care, comprise the largest part of the Dental Select Platinum Network. Nationally, General Dentists make up 79% of professionally active dentists and 21% are Specialists.

Dentists are listed in the Dental Select Platinum Network directories which are made available on-line and updated weekly. The electronic directory displays languages spoken by the office.

Network Criteria & Information

Building the Network

Dental Select is committed to offering a robust national network of dentists. We partner with network leasing companies who recruit dentists by:

- utilizing data identifying dentists who are currently providing services to members;
- members referring their dentist for recruitment into the Network;
- determining where members live and work then focusing recruiting efforts in those areas; and,
- recruiting based on the needs of current and new customer business.

Our goal is to make accessing services from an in-network dentist convenient and efficient.

Selection Criteria

Before joining the network, all dentists are credentialed based on established criteria to certify they meet our high standards for participation in the network. The credentialing process includes verification of dental licenses, education and malpractice insurance along with other items to ensure the dentist meets credentialing participation requirements.

Source of Information

Information about the dentists appearing on our website is obtained from an application that is completed and signed by the dental care professional. This information is updated periodically through credentialing outreach efforts by the appropriate leased network to the dentist, and through communications received from the dentist when changes occur.

Network Adequacy

Dental Select reviews its network size and actual in-force business for potential adjustment to its network. Through regular geoaccess reporting, Dental Select monitors the projected network target and actual performance. If Dental Select is not meeting its target goals, a recruitment project plan may be created. A coordinated effort to add additional dentists to the Network happens in conjunction with the leased network partner's assigned Provider Network Representative for the area and the Dental Select Provider representative who coordinates telemarketing and office visits. The Provider Network team is responsible for the recruitment and persistency of the network. These activities are reviewed on a quarterly basis by the Ameritas Quality Management Program Committee.

The Ameritas Quality Management Committee is responsible for ensuring that the organization's quality management program is fully operational. The Quality Management Committee Policy contains information about the activities and responsibilities of the Committee. This committee reviews and evaluates the results of quality management activities, institutes needed actions, and ensures follow-ups, as appropriate. Reports of the Committee's review are prepared semi-annually and presented to Ameritas' senior management.

Network Target:

	Geographic Type				
Provider Type – the plan provides access to at least one dental provider for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Dentist	15	30	60	75	110

The Dental Select leased networks will make reasonable efforts to contract with providers in extremely rural areas in any state as well as geographic areas with recognized maldistribution of dentists.

Service areas are generally approved for an entire state. The size and location(s) of the network providers may be presented to an employer prior to the sale of the dental insurance. Dental Select monitors the availability of a network provider's practice by analyzing statistics indicating current employee locations and provider utilization. Monitoring is also done through provider, member, client, and broker feedback.

Providers are allowed to apply for participation in the network at any time during the year. If necessary, Dental Select will coordinate with leased networks to recruit providers by targeting specific areas. We commonly utilize feedback from members and our sales distribution in our recruitment efforts, as well as telemarketing, mailing, and personalized delivery of network participation information.

Members may request that we send recruitment information to their current providers. With permission, the member's name may be used in communication to the prospective provider.

Dental claims from telehealth licensed dentists are processed in accordance with the member's benefit coverage. While members may utilize a telehealth dental provider and receive benefits under their dental plan, these providers are not uniquely identified in the provider directory.

Network Leasing

In those situations where Dental Select proposes to contract with an independent network of providers through a network leasing arrangement, Dental Select will conduct due diligence at the onset prior to the agreement to ensure that the network has established credentialing and quality improvement standards. During the term of the agreement, Dental Select will periodically monitor to ensure that the standards agreed upon are satisfactorily being met.

Dental Select has a network leasing arrangement with PPO USA, Inc./Connection Dental. Members have access to network providers via the Dental Select website electronic directory and/or a paper directory listing. This leased network is required to submit an updated list of providers no less frequently than monthly.

The leased network is responsible for the credentialing standards of all their providers and is expected to comply with all state regulations. Dental Select retains oversight responsibility to ensure that the credentialing and quality assurance standards are consistent with those required by the state. A delegated credentialing audit is performed for each leased network on an annual basis.

Referrals

Ameritas members have the freedom of choice in the selection of a provider and may change providers without informing Dental Select. Members are not required to choose or designate a primary care provider. Dental Select does not require the member to contact its office to select or change providers.

Members and network providers have access to directories listing Dental Select's network providers. Although members can seek care in or out of network without referrals, savings are maximized by visiting in-network providers.

Network Availability

Network providers are required to maintain sufficient staffing and equipment and, appropriate office hours necessary to provide dental services.

This will be monitored through provider surveys and complaint tracking.

Network providers agree to provide services in the same manner in which they provide services to their other patients and will not discriminate on the basis of age, sex, ethnicity, race, color, national origin, creed, ancestry, marital status, religion, sexual preference, health status, disability, participation in a Dental Plan or source of payment.

Emergency Services

Network providers are required to provide or arrange for twenty-four (24) hour per day, seven days per week emergency care service. Ameritas expects that appointments will be offered to all members upon request within this timeframe. Members are not required to contact or obtain approval prior to obtaining routine or emergency dental services.

Dental emergency refers to those services which are needed immediately because of an injury or unforeseen medical condition. Examples of an emergency service are those services required for the temporary relief of pain, infection or swelling.

Emergency and Specialty Care

Members have the freedom of choice to seek services from either a participating or non-participating specialty care provider, or in the case of an emergency, any provider of a members' choosing. Benefits will be paid for all services which are considered covered expenses as defined within the member's certificate. Members may change providers at any time and may do so without notifying Dental Select. Members are not required to contact Dental Select prior to obtaining treatment although it is suggested that members or their provider submit a pretreatment estimate in advance to the start of treatment when reasonably possible so that they will better understand benefits payable for the proposed treatment. Members do not need to contact Dental Select to be referred to another provider.

Access to Participating Providers: If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

Language Assistance and Special Needs

The provider application form requests the different languages that are spoken in the office. This information is documented in our system and languages spoken are displayed on online directories found on our website. Members are always welcome to contact us to inquire what additional languages are spoken in a particular office.

Dental Select will provide, at the request of a member, the conversion of the written English version of a certificate of coverage into written text in Spanish free of charge. Dental Select may also provide other plan materials in Spanish upon member request.

Dental Select provides access to in-house Spanish interpreters and contracts with external nterpretation vendor Language Line Services.

Dental Select uses an online chat service to communicate with the hearing impaired.

Upon request Dental Select will provide large print documents or oral information. Dental Select will also outsource to an outside vendor to provide certain written materials in Braille.

Provider network applications contains questions about access for the physically disabled. A handicap indicator is present in the provider directory for each provider listed. Responses from each office are maintained by the leased network with the provider's file and are accessible should a member have questions about these types of accommodations.

Network providers are required by contract to comply with all applicable federal, state and municipal laws. This would include complying with the Americans with Disabilities Act, as applicable.

Methods for Assessing Health Care Needs and Member Satisfaction

A regular review of network complaint tracking and trends are presented to both the executive officers of the Ameritas Group Division as well as to members of the Quality Management Committee. This activity is reviewed carefully to ensure that Dental Select and its leased contracted providers are meeting the expectations of members.

Surveys are mailed to segments of Producers, and Insured Members with a valid email address on file. In the case of customer satisfaction surveys where a major objective of the research is to improve the handling of customers' difficulties or complaints, survey responses requiring follow up and ad hoc requests are triaged through designated business area inboxes. Survey questions may be changed to meet current business needs. Data is tracked over time to measure and monitor improvements. Executives and Associates within the organization review the results, recommend changes to enhance service and may develop action plans, as needed.

Communication With Members

Members are informed about their plan and its features through enrollment materials, their certificate of coverage, and the public website including a secure member portal, and ID cards.

Members may search Dental Select's website for a network provider in their area at any time or they may call toll-free at 800-999-9789.

Grievance notice information is included with the member's certificate of coverage, and is also included on our website along with State and Federal appeals rights. Members may also contact us at the above toll-free number to obtain information about their appeal rights.

The following is a general overview of the levels of grievance reviews. Members are urged to consult the Notice of Grievance Procedures in their certificate of coverage for further detailed information.

Internal Grievance Review

A written grievance concerning any matter, including an adverse determination, may be submitted by the Member or his or her designated representative, within 180 calendar days of receipt of the adverse determination. We will send a written decision within a reasonable period of time appropriate to the Members medical condition but no later than 30 calendar days after receiving a request.

Expedited Review

Pre-authorization of benefits is not required under our plan. For urgent care situations, an expedited review of an elective pre-treatment benefit determination can be requested orally or in writing. We will make a decision and notify the Member or their designated representative no later than 72 hours after the carrier's receipt of request. Written confirmation of the decision will be provided within 3 calendar days of the decision, if the initial decision was not in writing.

External Review

The Member has a right to request an independent external review if there still remains a difference of opinion following any internal reviews or, if we fail to properly follow required Internal Review procedures. The Member or representative may request an External Review 4 months after receipt of an adverse decision following a grievance review. When we receive a request for external review, we will notify and send a copy of the request to the Commissioner of Insurance within 2 business days.

Expedited External Review

Upon receipt of a request for an expedited external review, we will notify and send a copy of the request to the Commissioner of Insurance within 1 business day electronically or by telephone or facsimile.

Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. The names, titles and qualifying credentials of the Persons participating in the grievance review process.
2. A statement of the reviewers' understanding of the grievance.
3. The decision stated in clear terms, and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision.

4. A description of our review procedures, any time limits applicable to such procedures, and any appeals rights.
5. A description of any additional material or information necessary and an explanation of why such material or information is necessary for any further review.
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or a statement that such rule, guideline, or protocol, was relied upon and that a copy will be provided free upon request.
7. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided free of charge upon request.
8. For first level reviews, a description of the process to obtain a second level grievance review and the time frame for review. Following a second level review, a description of the process to request an independent external review.
9. Notice of the Member's right to contact the Colorado Division of Insurance

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Continuity of Care

Either party may terminate the network agreement without cause upon 90 days' advance written notice.

Irrespective of whether the termination is without cause or with cause, Dental Select will notify members seen on a regular basis of the provider's contract termination date in writing. This notice will be sent within 15 working dates of receipt or issuance of a notice of termination and will advise how the member may obtain information regarding other participating providers in the network. Network providers are expected to complete any procedure in progress on the member.

Network provider agreements contain hold harmless language that in the unlikely event Dental Select is unable to continue its operations or becomes insolvent, notice of Dental Select's inability to continue its operations or insolvency will be communicated to policyholders in writing. Network providers are expected to continue to provide covered services to any member receiving active treatment on the date of insolvency or the cessation of operations until the course of treatment is completed or Dental Select's orderly transition of coverage to another carrier.

Network provider agreements also require the provider to accept payment directly from Dental Select for covered services and not balance bill the member beyond the amount of their contracted fee.