West Virginia Network Access Policy

Purpose: This policy has been developed to document the Company's efforts to ensure dental care services are available and accessible to enrollees within a geographic area with adequate facilities, locations and personnel.

Policy Requirements

TruAssure network coverage is offered in association with the DenteMax Plus dental network arrangement, which includes participating dentists from the United Concordia, DenteMax and Connection dental networks. DenteMax plus is responsible for maintaining our provider network. TruAssure is responsible for maintaining provider records, adjudications of claims, and enrollment and maintenance of member eligibility. TruAssure Insurance Company is a wholly owned subsidiary of Delta Dental of Illinois. Delta Dental of Illinois has no direct affiliation with DenteMax.

1. Availability and Accessibility Standards

Standards have been established to ensure that dental care is available and accessible to enrollees in a geographic area with adequate facilities, locations and personnel. The Quality Management Committee reviews reports of actual access no less than annually based on geographic regions to ensure compliance with the established standards, and when required, makes recommendations for changes to the standards or opportunities for focused recruitment. The standards are as follows:

- Availability Standards:
  - Urban – 1 provider in 10 miles
  - Suburban – 1 provider in 15 miles
  - Rural – 1 provider in 30 miles
  - At least 70% of the network is accepting new patients. This will be noted in the Directory.

- Accessibility Standards:
  - Routine care – within 60 days
  - Urgent care – within 24 hours
  - Dentist for Pediatric only – 30 minutes travel time from member residence and/or 25 miles
  - Oral Surgeon and Orthodontist – 60 minutes travel time from member residence and/or 45 miles

2. Teledentistry

TeleDentistry.com services are included in existing coverage for our members. In addition to a virtual consultation, a TeleDentistry.com dentist can write prescriptions when appropriate and refer an in- network dentist if additional treatment is needed. For more information, visit truassureblog.com/virtual- visits or call our 24/7 helpline at 866-256-1752.

3. Emergency care

Network Vendor ensures that the provider agreements require dentists to have the ability to direct enrollees to emergency services 24/7. Emergency Dental Care is covered and can be received from any Dentist. Benefits for Emergency Dental Care will be paid at in-network benefit levels. Members are informed what dental emergency care includes in their policy documents.

4. Insufficient Network Coverage Process

Out of network services will be paid at the in-network fee when an in- network provider is not available within the driving distance or appointment wait times. All network exceptions will be processed based on the required availability and accessibility standards of the state where the member resides.

- If a member is unable to schedule an appointment with an in-network dentist due to driving distance or appointment wait times, they should contact a Customer Service Representative should the member need to seek treatment from an out-of-network provider.

- The Customer Advocate will note in the system, once need is verified, that the member will seek treatment from an out-of-network provider. The Customer Advocate Service Representative will note in the system so that the member will receive in-network benefits.

- If a claim is paid at the out of network reimbursement from an out of network dentist due to the network not meeting standards listed in this policy, the claim will be adjusted to the in network reimbursement.

    - Claim Operations will ensure that out of network services are paid according to the standards outlined in the Provider Accessibility Policy.
    - Compliance with this policy will be monitored by the Carrier no less frequently than annually.

5. Choosing a Dentist and Referrals

Covered Individuals may choose to go to any licensed dentist whenever dental care is needed. Whatever dentist the Covered Individual chooses, he or she will receive some level of benefits for Covered Dental Services. However, there are advantages when the Covered Individual

receives treatment from a network dentist.

Referrals and prior authorizations are not required for any TruAssure Insurance Company insurance policy. Members may choose which dentists and specialists they visit and are free to choose in-network or out of network providers for any services. TruAssure has no requirement related to referrals within or outside of the network.

6. Provider and Facility Types

See Exhibit A for a list of provider and facility types available by network and by county in West Virginia.

7. Provider Directory Standards

A. Provider Directory Information

- Includes Information on whether providers are accepting new patients
- Includes Information if a provider has age restrictions
- Includes frequency of directory updates
- Languages spoken in office when available

B. Provider Directory Sufficiency

- The following are considered when determining access sufficiency:
    - Availability of a type of provider in a geographic area
    - Provider/covered person ratios by specialty
    - Geographic accessibility of providers
    - Geographic variation and population dispersion
    - Waiting times for an appointment with participating providers
    - Providers accepting new patients
    - Hours of operation
- If the network is determined to be insufficient, TruAssure will request that DenteMax create a provider recruitment plan in a specific geographic area.

C. Provider Directory Audits

The Company delegates the creation and maintenance of a dental network do DenteMax. The Company has oversight of the process for auditing provider directories as per all state and federal requirements.

See the DenteMax policy for performing Directory Audits at Exhibit C.

8. Member servicing

The Company has a dedicated staff for servicing members. Qualified and adequately trained

staff, sufficient for ensuring the prompt servicing of members, respond to inquiries related to eligibility, benefits, claims, network dentist locations, and other issues. For information on how to file appeals and the appeals process see the Appeals Process Information Packet attached as Exhibit B.

A. Assessing Health Care Needs

TruAssure surveys members who had claims each quarter. Surveys are sent via email using a third party survey tool. Questions include their satisfaction with TruAssure and its service. We measure net promoter score (NPS) and customer effort score (CES), as well as ask open-ended questions regarding what TruAssure does well and where we can improve. TruAssure offers the opportunity for members to leave their contact information for follow up regarding survey responses if they choose.

B. Provider Directory

- Provider Directories are updated weekly.
- Members may search for providers at https://www.truassure.com/find-a-provider.
- Members may obtain printed copies of provider directories by calling Customer Service 1- 888-559-0781, 8:30 a.m. to 5:00 p.m. central time, Monday through Friday or by email at Individual@TruAssure.com. Printed directories will be mailed to members within 5-10 business days.
- Members are informed of how to access the provider directory in their dental plan documents.

C. Continuity of Care in the Event of Contract Termination

TAIC advocates for its members by facilitating a plan for continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. Members should contact Customer Service for assistance 1-888-559-0781, 8:30 a.m. to 5:00 p.m. central time, Monday through Friday or by email at Individual@TruAssure.com.

DenteMax Preferred Dentist Reference Guide states, "In the event of termination of your Provider Service Agreement with DenteMax, you are obligated to continue to provide and complete treatment begun prior to the effective date of your termination at the fees detailed in your DenteMax fee schedule".

D. Coordination and Continuity of Care

Members do not need a formal referral or pre-approval to seek care with a specialist. TruAssure does not have a requirement related to choosing or changing providers, members are able to choose or change providers based on their dental health needs.

E. Language Access

It is TruAssure Insurance Company's policy to make access available for persons with limited English proficiency. TruAssure has customer service employees that are fluent in Spanish and English. For other languages we contract with an interpretation service that allows us to provide interpreters by telephone. Most documents are available in English or Spanish and can be translated on request to other languages. All TruAssure insureds, their dependents, and providers are eligible for services in any language. These services are provided free of charge regardless of the TruAssure product. The phone number to access our service representatives, and translation services when needed, is provided on the member's ID card, enrollment welcome packet, and our Explanation of Benefit statements.

DenteMax network dentists include language capability for individuals desiring to see non-English speaking providers.

F. Health Care Services and Benefits

Members are informed of the benefits they have access to and what the coverage levels are in their insurance policy and schedule of dental benefits.

Exhibit A

Provider and Facility Types UCCI – Below is a listing of specific provider and facility types available within the network by West Virginia county.

Provider/Facility Type Available	County Name
General Dentistry	Cabell Hardy Monongalia Wood
Endodontist	Harrison Kanawha Wood
Oral Surgeon	Cabell Kanawha Mercer Randolph Ohio Putnam Raleigh Wood
Pediatric Dentistry	Ohio Putnam Raleigh
Orthodontist	Berkeley Hancock Harrison Jefferson Monongalia Ohio
Periodontist	No providers
Prosthodontic	No providers

Provider and Facility Types Connections – Below is a listing of specific provider and facility types available within the network by West Virginia county.

Provider/Facility Type Available	County Name
General Dentistry	Boone Braxton Brooke Calhoun Doddridge Grant Mason Mingo Wayne Greenbrier Hardy Harrison Ohio Taylor Berkeley Fayette Raleigh Cabell Hancock Kanawha Monongalia Putnam Wood
Endodontist	No providers
Oral Surgeon	No providers
Pediatric Dentistry	Berkeley
Orthodontist	No providers
Periodontist	No providers
Prosthodontic	No providers

Provider and Facility Types DenteMax – Below is a listing of specific provider and facility types available within the network by West Virginia county.

Provider/Facility Type Available	County Name
General Dentistry	Doddridge Greenbrier Lewis Marion Mercer Randolph Taylor Tucker Hardy Preston Braxton Mineral Mingo Raleigh Berkeley Hancock Logan Brooke Nicholas Putnam Monongalia Ohio Fayette Lincoln Harrison Wood Wayne Kanawha Cabell
Endodontist	No providers
Oral Surgeon	Jackson Kanawha Monongalia Randolph
Pediatric Dentistry	Ohio Putnam Raleigh
Orthodontist	Brooke Kanawha Mercer
Periodontist	No providers
Prosthodontic	No providers

Exhibit B

TruAssure Insurance Company

Health Care Insurer Appeals Process Information Packet

CARULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process
Help in Filing an Appeal

We must send you a copy of this information packet when you first receive your policy. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at 888-559-0779 to ask. There is someone available to answer your call at least five days a week during normal business hours.

No employee or other individual employed by TruAssure Insurance Company receives any compensation, financial, or other incentives based on reduction of services or claims or the number of denials or certifications made on claims or appeals.

How to Know When You Can Appeal

When TruAssure Insurance Company does not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "dentally necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the maximum plan allowance amount.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.

4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with TruAssure's Grievance Department.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non- urgent services or denied claims)
Level 1. Expedited Dental Review	Informal Appeal
Level 2. Expedited Appeal	Formal Appeal
Level 3. Expedited External Independent Dental Review	External Independent Dental Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company and is a certified review agent, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Dental Review

Your request: You may obtain Expedited Dental Review of your denied request for a service that has not already been provided if:

• You have coverage with us,

• We denied your request for a covered service, and

• Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Appeal and Formal Appeal

process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Appeals Department
TruAssure Insurance Company
111 Shuman Blvd
Naperville, IL 60563
888-559-0779
Fax 630-718-4982

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level *2*: Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider ***must immediately*** send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider hasn't already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels

1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Appeals Department
TruAssure Insurance Company
111 Shuman Blvd
Naperville, IL 60563
888-559-0779
Fax 630-718-4982

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Dental Necessity Reviews
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not dentally necessary to treat your problem. For dental necessity cases, an independent reviewer, who is completely independent from our company and is a certified review agent makes the decision. The provider must be a provider who typically damages the condition under review. If the independent reviewer decides that we should provide the service, we must authorize the service. If the independent reviewer agrees with our decision to deny the service, the appeal is over.

(2) Administrative Reviews
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Appeal

Your request: You may obtain Informal Appeal of your denied request for a service or claim if:

• You have coverage with us,
• We denied your request for a covered service or claim,
• You do not qualify for an expedited appeal, and
• You or your treating provider asks for Informal Appeal within 180 days of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Appeals Department
TruAssure Insurance Company
111 Shuman Blvd
Naperville, IL 60563
888-559-0779
Fax 630-718-4982

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service [or pay your claim]. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2.

If we grant your request: The decision will authorize the service [or pay the claim] and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Appeals Department
TruAssure Insurance Company
111 Shuman Blvd
Naperville, IL 60563
888-559-0779
Fax 630-718-4982

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 30 days to appeal to Level 3.

If we grant your request: We will authorize the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Appeals Department
TruAssure Insurance Company
111 Shuman Blvd
Naperville, IL 60563
888-559-0779
Fax 630-718-4982

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Dental Necessity Reviews
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not dentally necessary to treat your problem. For dental necessity cases, an independent reviewer, who is completely independent from our company and is a certified review agent makes the decision. The provider must be a provider who typically damages the condition under review. If the independent reviewer decides that we should provide the service, we must authorize the service. If the independent reviewer agrees with our decision to deny the service, the appeal is over.

(2) Administrative Reviews
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy.

Obtaining Dental Records

You may ask for a copy of your dental records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your dental records. The dental records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your dental records only to yourself or your health care decision-maker.

Confidentiality: Dental records remain confidential. TruAssure follows all state and federal laws regarding privacy of dental records. If you participate in the appeal process, the relevant portions of your dental records may be disclosed only to people authorized to participate in the review process for the dental condition under review. These people may not disclose your dental information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

Exhibit C

DenteMax, LLC Directory Validation Policy and High-Level Procedures	**Policy Custodian: Rebecca French** **Approved By:** **Approval Date:** **Effective Date: 10/1/2022** **Next Review Date: 10/1/2023**

I. Introduction

This policy and procedures document formalizes the minimum requirements of directory validation for DenteMax, LLC.

II. Purpose and Scope

This policy addresses the requirements we must meet to be compliant with state and federal regulations:

- Appropriate requirements are met in states where there is legislation to maintain provider directories
- Appropriate requirements are met for the Consolidated Appropriations Act (CAA)

III. Directory Validation Requirements

Clearly defined requirements must exist to ensure provider directories contain accurate information.

- Individual state regulations dictate frequency and scope of validation
    - Outreach is made to providers via mail, email, and/or phone in order to validate information
    - Requested updates are made to provider directories
- The federal law, Consolidated Appropriations Act (CAA), dictates the provider must validate their directory information every ninety days
    - Outreach is made to providers via email
    - Requested updates are made in provider directories

This policy covers directory validation for:

- All DenteMax providers

IV. High-Level Procedures

The following high-level procedures are used by DenteMax, LLC to validate provider directories.

State Regulated Directory Validation

The Directory Validation Team will conduct outreach as outlined by the individual state regulations via mail, email and/or phone. Required updates to individual provider directories will be made to ensure correct information is published in these directories. If state regulation dictates, a provider will be suppressed in the appropriate directory upon failure to comply. See V. State Specific Procedures.

Federal Regulated Directory Validation

In accordance with the Consolidated Appropriations Act (CAA), the Directory Validation Team will conduct outreach via email to providers requesting they validate their directory information every ninety days. Required updates to individual provider directories will be made to ensure correct information is published in these directories. Per this regulation, a provider will be suppressed in the appropriate directory upon failure to comply.

V. State Specific Procedures

The following state specific regulations are used by DenteMax, LLC to validate provider directories.

West Virginia State Regulated Directory Validation

The Directory Validation Team, in accordance with W. Va. CSR 114-100-7 will conduct outreach no less frequently than three times during each plan year. The team will audit at least fifty percent of the providers contained in its provider directories for accuracy and update that directory based upon its findings. Every provider in the directory will be audited at least once during each plan year. Audits will be conducted such that all entries in a provider directory will be audited at least once every eighteen months. Documentation of the process and findings of all audits and the information required by this rule will be retained for no less than thirty-six months and will be made available to the Commissioner upon request.

VI. Revision History

Version	Date	Revision Overview	Author
1.0	10/1/2022	Original Procedure	Rebecca French