STATE OF CONNECTICUT

INSURANCE DEPARTMENT

DENTAL NETWORK ADEQUACY SURVEY

Carriers should complete the Network Adequacy Survey and file electronically no later than April 1, 2019. Surveys and applicable documents should be sent to: LHCompliance@ct.gov

Provide a contact person should there be any questions or requests for additional information.

Name of Company: UniCare Life & Health Insurance Company

Name of Network (as marketed): Dental 300

Address: 233 South Wacker Drive, Suite 3700, Chicago, IL 60606

Contact Person: Abigail Arroyo

Title: Regulatory Oversight Manager

Direct Phone #: (312) 234-8050

E-mail Address: abogail.arroyo@anthem.com

Please note that all responses, letters, and data provided must be Connecticut specific for Fully Insured plans. Responses that include processes, letters or data for jurisdictions outside of Connecticut or for Self-Funded plans will be rejected.

A separate filing needs to be filed for each network offering. If you are using multiple leased networks together to create one network offering, you should file it together under one filing and include appropriate documentation for each leased network(s).

Carriers are responsible for addressing all the questions, regardless of whether they own or lease their network(s). Any response with an attachment (document / policy / procedure) should clearly indicate where in the document the specific response is addressed (including page number and section).

Questions answered as "N/A" will not be accepted. No response to a question or policy will not be accepted.

Please submit the surveys in word format, not PDF.

GENERAL INFORMATION

QUESTIONS		RESPONSES
1.	Does the health carrier utilize its own, leased, or a combination of owned and leased network(s)?	Unicare: UniCare utilizes our affiliate network under Anthem BCBS.
1a.	If the health carrier leases network(s), please provide the name(s) of network(s) leased:	N/A as we do not lease our networks.

STANDARDS & RESPONSIBILITIES TO THE PROVIDER

QUESTIONS		RESPONSES	NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND
1.	Specify the average term of a provider contract. Do contracts vary by specialty? Do the contracts renew automatically?	Our contracts automatically renew annually, they do not vary by specialty, and are considered "evergreen".	N/A
2.	Verify that all provider contracts include a clause that hold covered persons harmless from balance billing beyond any contractual cost sharing amounts.	Hold Harmless language is included in our provider contract. Below is the specific language. In no event, including, but not limited to, nonpayment by Anthem, insolvency of Anthem, or breach of contract between Anthem and Dentist, shall Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a Covered Person's designee, other than Anthem, for Covered Services provided, except that Dentist may collect any Cost Share.	UNICARE: PPO-03G Rev 2018 v2, Section 7.17 page 9

3.	Describe how the health carrier and participating providers are meeting the requirement to provide at least ninety days' written notice to each other before the health carrier removes or the participating provider leaves the network.	When either party terminates there are converations prior to the submission or after the submission if the 90 days requirement is not being followed. There is language in the contract that requires the 90 day notification to which Anthem will direct providers to if they are unaware of the requirements. Providers are required to notify UniCare at least 90 days prior to leaving the network. The provider agreement includes the following provision: 6.2 Termination of Agreement. Except as otherwise set forth in the applicable State Specific Provisions, either party may terminate this Agreement in accordance with this Section. 6.2.1 Either party may terminate this Agreement at any time, without cause, by giving at least ninety (90) days prior written notice to the other party. Termination shall be as set forth in the notice.	UNICARE: PPO-03G Rev 2018 v2, page 7

4.	Describe the process in place to ensure that each participating provider provides the health carrier, no later than 30 days after receiving a notice of removal or issuing a departure notice, a list of covered persons that are covered under the health plan and are being treated on a regular basis (receiving treatment at least once during the previous 12 months).	We notify the providers to supply the information in conjunction we are gathering claims untilization for patients who have been seen by the provider within at least once within 18 months whether we get the listing from the provider or not to ensure we notify members impacted. Dental providers most likely will not know from their entire list of patients who are still eligible or active unless they reach out to the Plan. If Dental 300 were to have membership, the Plan will run utilization over the past 18 months to identify regular patients that have been seen by particular dentist who is terminating, so we can notify those members still showing eligible for benefits of the change in participation status of the provider. Language included in the contract: 6.2.4 In accordance with Connecticut General Statutes § 38a-472f, upon receiving or submitting a termination notice, Dentist is required to provide a list of Covered Person/patients of record to Anthem.	UNICARE: PPO-03G Rev 2018 v2, page 7

5.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to payment terms, such as submission of claims and reimbursement terms.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. Included in our provider contract and Dental Provider Reference Manual. When the provider office contacts Customer Service they would be advised of the detials on how to send a claim to the claims department including the mailing address or electronic submission information. Any quesitons around payments of claims would be researched and be answered based on the policy, the providers status and the detials provided on the claim form. •Contract • Anthem BCBS PPO Provider Manual_2019 •The claims processing guidelines which is an addendum to the provider contract. •Newsflashes •Providers are responsible for contacting our customer service department.	Anthem BCBS PPO Provider Manual_2019 Dental Programs's Claims Processing Guidelines for 2019 NDM 27 Policy CT Ongoing Education PPO-03G Rev 2018 v2

6.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to utilization review.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 •The claims processing guidelines which is an addendum to the provider contract. Providers are informed via the Anthem BCBS PPO Provider Manual_2019 section Claims Review Submission Guidelines (pages 103 and 107)	Dental Programs's Claims Processing Guidelines for 2019 Anthem BCBS PPO Provider Manual_2019 PPO-03G Rev 2018 v2, section 2.7
7.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to quality assessment and improvement programs.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	Anthem BCBS PPO Provider Manual_2019 PPO-03G Rev 2018 v2

8.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to credentialing and re-credentialing.	Detailed requirements are mailed, emailed, and faxed to providers during the credentialing and recredentialing process. Providers are notified by instructions within the Initial credentialing application and re-credentialing application process of any deadlines or expectations to become participating or continue to participate. If a provider does not meet the standards of credentialing they will be notified in writing. It's NCQA industry standard wide that NCQA level providers are re-crendentialed every three years. UniCare notifies providers via letter six months prior to re-credntialing due date. Anthem BCBS PPO Provider Manual_2019 UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	Anthem BCBS PPO Provider Manual_2019 CR 8 Policy Initial Credentialing approved 121918 CR 11 Policy Re-Credentialing approved 121918 PPO-03G Rev 2018 v2

9.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to data reporting requirements.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 •The claims processing guidelines which is an addendum to the provider contract. Dentist will provide the same levels of service and appointment availability for Covered Persons as for his/her other patients. Dentist agrees not to differentiate on the quality of service because of health status or payment source/Sponsor. Dentist shall offer the same appointment availability for all patients regardless of health status or payment source/Sponsor. Dentist shall not close the office to new patients due to health status or payment source/Sponsor. UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	PPO-03G Rev 2018 v2 Dental Programs's Claims Processing Guidelines for 2019 Anthem BCBS PPO Provider Manual_2019, Section 1, page 4

10.	Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to reporting requirements for timely notice of changes in practice, including but not limited to discontinuance of accepting new patients.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. When the provider contacts customers services the agent would research to see if the provider records have been updated and if they have not they would advise the provider that they would need to submit any information about this change to our network department to have the records updated and for greater detail customer service would transfer them to provider networks. •Contract • Anthem BCBS PPO Provider Manual_2019 •The claims processing guidelines which is an addendum to the provider contract. •Providers are responsible for contacting our customer service and networks departments. •Standardized Maintenance Form which is posted to our website. UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	UNICARE: PPO-03G Rev 2018 v2 Anthem BCBS PPO Provider Manual_2019

11.	Describe the process in place to notify participating providers of their responsibilities to the health carrier's applicable administrative policies and programs in regard to confidentiality requirements.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	UNICARE: PPO-03G Rev 2018 v2 Anthem BCBS PPO Provider Manual_2019
12.	Describe the process in place to notify participating providers of their responsibilities to the health carrier's applicable administrative policies and programs in regard to any applicable federal or state programs.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	UNICARE: PPO-03G Rev 2018 v2 Anthem BCBS PPO Provider Manual_2019

13.	Describe the process in place to notify participating providers of their responsibilities to the health carrier's applicable administrative policies and programs in regard to collecting applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. •Contract • Anthem BCBS PPO Provider Manual_2019 •Providers are responsible collecting cost shares applicable to the member's dental plan and can contact our customer service department to assist in determining benefits. UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	UNICARE: PPO-03G Rev 2018 v2 Anthem BCBS PPO Provider Manual_2019

14.	Describe the process in place to notify participating providers of their responsibilities to the health carrier's applicable administrative policies and programs in regard to notifying covered persons, prior to delivery of health care services, if possible, of such covered person's financial obligations for non-covered benefits.	UniCare constantly informs and educates providers through different forms of communication on how to use the available tools for them such as those listed below to gather information. Providers are responsible collecting cost shares applicable to the member's dental plan and can contact our customer service department to assist in determining benefits. •Contract Contract Language: Language in the contract: 2.19 Payment in Full. Dentist agrees to accept as payment in full the applicable Anthem Rate, as specified on the Plan Payment Schedule, for Covered Services provided to Covered Persons/Members. Dentist shall look solely to Plan for compensation for Covered Services provided to Covered Persons/Members and under no circumstances shall he/she render a bill or charge to any Covered Person/Member except (i) Cost Shares; (ii) for non-Covered Services to Covered Persons/Members except when Dental Services are deemed to be not Covered Services under Utilization Management; or (iii) for services provided after the individual ceases to be a Covered Person/Member. This paragraph shall	UNICARE: PPO-03G Rev 2018 v2

		survive termination of this Agreement for any reason.	
15.	Describe the procedures in place for the resolution of administrative, payment or other disputes between the health carrier and a participating provider.	Disputes are directed to Anthem's Grievance and Appeals department, with a response time of 30 days. a. The Appeals Department standard is to acknowledge receipt of Appeals within 5 calendar days and to process 100% of all post-service Appeals within 30 calendar days and 100% of all pre-service Appeals within 30 calendar days. UniCare utilizes our affiliate network under Anthem BCBS.	Anthem Connecticut Appeals PP, top of page 2

16.	Describe how providers are notified of any referral process, both for referrals within and outside the network. If referrals are not required, how are providers informed of this?	Referrals are not required. Members are not assigned to a primary provider and members can select any provider they're interested in seeing at any time. None of the dental plans that Anthem participating providers service require a referral. Members can select any provider they want. Many dental plans have out of network benefits and therefore members may prefer to see a non-participating provider. Participating providers agree to provide dental services to all members in accordance with the member's dental plan. Again, none of the dental plans require a referral. Providers can call Customer Service on any particular member to inquire if a referral is required for member to be seen by specialist. Our Dental PPO network in CT and across the country do not require authorization or referral to a participating specialist. If Anthem offered a dental product or network that required notification to a participating specialist we would include that information to the provider. Neither Anthem nor Unicare have a dental health maintenance organization product or network in the state of CT, which typically requires authorization for participating specialists. Anthem BCBS PPO Provider Manual_2019 contains language in	Anthem BCBS PPO Provider Manual_2019, page 21 CT 201708241549, page 7

		regards to referrals are not required. UniCare utilizes our affiliate network under Anthem BCBS.	
17.	Describe the process in place (including newsletters, emails, etc.) for notifying participating providers on an ongoing basis of the specific covered health care services for which such participating provider will be responsible, including any limitations on or conditions of such services.	UniCare educates providers on claims processing guidelines through daily activities such as phone calls in addition to amendments and newsletters on an annual basis. Providers can access plan benefits and limitations at www.availity.com/dentalproviders. Providers can access plan benefits and limitations at www.availity.com/dentalproviders. UniCare utilizes our affiliate network under Anthem BCBS the Anthem Dental Provider Manual would apply.	N/A

18.	Describe the process in place for enabling participating providers to determine, in a timely manner at the time benefits are provided, whether an individual is a covered person or is within a grace period for payment of premium. How are providers informed of this process?	We notify providers of grace periods eligibility via newsletter for providers to contact Customer Service. UniCare educates providers on claims processing guidelines through daily activities such as phone calls in addition to amendments and newsletters on an annual basis. All Providers may contact Anthem by phone for Eligibility and benefit information. They can receive information in our IVR system which is available 24 hours a day 7 days a week. They may also speak with a representative to obtain the information verbally. Or They can review plan benefits, Eligibility, and limitations by registering online at www.availity.com/dentalproviders. UniCare utilizes our affiliate network under Anthem BCBS.	N/A

STANDARDS & RESPONSIBILITIES TO COVERED PERSONS

QUESTIONS	RESPONSES	NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND

1.	Describe how the health carrier is meeting the requirement of sending a written notice to all covered persons being treated on a regular basis (receiving treatment at least once during the previous 12 months), notifying them that their provider is leaving or is being removed from the network. Attach a policy that describes the internal process and confirm that the written notice is sent to covered persons no later than 30 days after the health carrier issues or receives a written termination notice.	In Dental, Dentists tend to relocate much more frequently then doctors, and many dentists work for an Owner Dentist as an Associate Dentist within a practice and are paid at a salary. Our dental network has very low turnover rate, as many providers don't terminate the network, many of them move from one location to another without terminating their provider agreement. If we receive a termination letter that requires us to terminate networks, we do notify members, however, as an example, if Dr. Smith who is an associate says he is no longer at Office A and now at office B, we will not terminate this provider from the network, they relocated to a different physical address with the same network. Our policy is written for how our contracts are portable, otherwise, we would send termination notification to members when provider is still participating in the network which is not how we interpreted the law since members will still be able to access the provider as in-network. Anthem's regularly seen patient: Person who has received any exam (i.e. D0150, D0120, D140, D0145, D0160, D0180 etc.) once within 18 months. An exam is considered standard in diagnosis practice before a member can be treated. It is expected for members to	PS Process Aid 74 Member Notification NBPP Mandate (page 2)

		see their dentist twice a year and in order to capture the definition of regular that means being seen more than once in a timeframe, we go back 18 months to capture the once or more per year (i.e. if seen on Jan 15, 2018 and then seen again on Jan 20, 2019, 12 months have passed but we are still capturing the yearly visit in our data pull for notification. Within fifteen days receipt of provider termination Anthem sends notification to members. See below language in PS Process Aid 74 Member Notification NBPP Mandate. If deemed the last active provider participating at the clinic and is proceeding with the termination NDM provides education to the provider that the plan will notify their regularly seen patients of their termination in approximately 15 business days of receiving termination notice. UniCare utilizes our affiliate network under Anthem BCBS.	
2.	Attach a sample letter sent to covered persons notifying them that their provider is leaving or is being removed from the network.	N/A	UniCare Provider Term letter_Redacted

3.	Confirm that all insurance contracts include information to inform covered persons of the network plan's grievance and appeals process.	Yes all of the certificates of coverages supplied to our covered members explain the process for the member on how their plan is administered and how to file a grievance or appeal. The customer also receives the details on all explanation of benefits after a claim processes.	N/A
4.	Confirm that all insurance contracts include information to inform covered persons of the network plan's process for covered persons to choose or change participating providers in the network plan, if applicable.	Our plans are PPOs and are open access and members may choose between in network and out of network providers, so a referral is not necessary. UniCare utilizes our affiliate network under Anthem BCBS.	N/A

5.	Confirm that all insurance contracts include information to inform covered persons of health care services offered by the network plan, including those health care services offered through the preventive care benefit, if applicable.	UniCare dental plans are no longer being actively marketed, however, our website UniCare.com provides detailed information to ensure the current members are provided methods of assistance with facts and questions they may have about their dental plan and providers, along with health and wellness assessments, information on health topics and preventive care guidelines. Specifically for dental, the UniCare website provides a Dental Insurance Overview that states the following: With UniCare Dental, members may receive: • 100% in-network coverage for diagnostic and preventive care on most dental plans -- which can be key to maintaining good long-term dental health. • Flexible plan designs, many which include coverage for popular services like composite fillings and dental implants. • An extra cleaning (for healthy teeth) or periodontal checkup (for healthy gums) each year for our diabetic and pregnant members, which do not count toward their yearly limit. • No waiting periods for major dental work.4 • Annual maximum carryover feature	N/A

		that lets members carry over some unused benefit dollars from one year to the next. • Access to international emergency dental care from our worldwide listing of credentialed, English-speaking dentists while traveling or working nearly anywhere in the world. In conclusion, the website provides the members access to Customer Service who is available to assist with questions and information that the member may require. EOBs are sent when claims are submitted to be paid. They would include remarks that help the member understand how benefits were paid or not paid.	

6.	Confirm that all insurance contracts include information to inform covered persons of the network plan's procedures for covering and approving urgent and specialty care.	The Anthem CT EXTRAS 102418 clean policy includes "Authorized Services" on page 17 to comply with the Connecticut Statutes in regards to Network Adequacy Access Standards. •Due to this plan only being a PPO product the members have the ability to utilize any dentist of their choice. If they want to save money they would utilize a network dentist. •For those members who live in an area with limited access to In-Network providers, an exception will be made to process claims as In-Network when they see an Out-Of Network provider. This exception would also apply in those instances when a member is experiencing a dental emergency and urgent care is needed. This benefit is available for all Individual and Group Plans and applies if there are no providers within a certain distance from the member's home: Dental Provider: Fairfield: 30 mins/15 miles All other Counties: 45 mins/30 miles •The In-Network Coverage percentage will be used and the claims will count towards the In-Network Deductible and Maximum. The claims will process using the charged amount as the	N/A

		allowed amount in order to have the patient responsibility be similar to In-Network. The member must call Dental Customer Service prior to each visit to determine if there are any new providers in their area. A detailed workflow has been shared with the Dental Customer Service team so that they are aware of how to bestassist our members when calls are received. The Anthem CT EXTRAS 102418 clean includes provision "Authorized Services" on page 17 to comply with the Connecticut Statutes in regards to Network Adequacy Access Standards. EOBs are sent when claims are submitted to be paid. They would include remarks that help the member understand how benefits were paid or not paid. UniCare utilizes our affiliate network under Anthem BCBS.	

7.	Describe how covered persons are informed of the process to cover an out-of-network provider at an in-network level of cost share to the member should there be no in-network providers within a reasonable driving distance, reasonable appointment scheduling timeframe, or accepting new members.	The members are informed in their benefits booklets that if there is not a participating dentist that we may authorize service(s) out of the network and that they would have to call customer service for the information. If they reach out to customer service they will review and explain the process per the policy over the phone. Also see Limited Access Policy (Anthem Dental CS) 09252018-v3 Update 02/04/2019 The Anthem CT EXTRAS 102418 clean clean includes a provision "Authorized Services" on page 17 to comply with the Connecticut Statutes in regards to Network Adequacy Access Standards. UniCare utilizes our affiliate network under Anthem BCBS.	Limited Access 02.04.19 CT EXTRAS 102418 clean

8.	Describe the internal process in place to approve coverage for an out-of-network provider at an in-network level of cost share should there be no in-network providers within reasonable driving distance, reasonable appointment scheduling timeframe, or accepting new members. Confirm that the time/distance and appointment wait time measures comply with Connecticut's standards.	When UniCare recieves a phone call the Customer Service agent will review the requirments for the members policy based on county for both General practice(GP) or Specialist: Fairfield: 30 minutes or 15 miles All other counties: 45 minutes or 30 miles and appontment availitbiity Urgent Care: 48 hours Non-Urgent GP: 10 business days Non-Urgent Specialist: 15 business days. The Customer Service agent will grant permission for the customer to see an out of network office if there is no one avaiable to see the member. They will supply the customer with the detials on filing the claim and that the member must call per visit for any additonal approvals. Once the claim is sent to the agent's attention they will scan the claim and send it over to a supervisor who will file the claim to the claims department for processing. UniCare's appointment wait time measuremes comply with Connecticut's standards.	Limited Access 02.04.19 Anthem BCBS PPO Provider Manual_2019

9.	Confirm that the timeframe for approving out of network requests, including for instances where there is network inadequacy, falls within Connecticut's Utilization Review standards.	Members who call the plan to request out of network service(s) bases on network adequacy for the CT standards will be notified during that call whether their request for service(s) at an out of network provider will be approved. If approved documentation is then placed in the members account for that claim to be paid accordingly based on that approval.	N/A
10.	Describe the policies in place for addressing the health carrier's and providers' ability to meet the needs of covered persons, including, but not limited to children and adults, with limited English proficiency or illiteracy. Attach both the internal policy as well as the member notification.	UniCare strives to ensure that there is access to the dental products and services for individuals with limited English proficiency, illiteracy, and spoken or written language translations. UniCare's customer service representatives are available to assist members. UniCare also mails language inserts explaining the customer rights which providers that information in their natural langauge with any outgoing correspondence. To help better serve our customers, UniCare representatives receive specialized training in areas such as service skills, problem-solving, our benefit plans, and providing language translations services to the customers.	Announcement_FED Mandated LEP and Nondiscrimination Taglines_CS_101716 Process for CS_LEP and Nondiscrimination Tagline Translation Requests.1… HCR EOB Language Insert Language Line Calls

11.	Describe the policies in place for addressing the health carrier's and providers' ability to meet the needs of covered persons, including, but not limited to children and adults, with diverse cultural or ethnic backgrounds. Attach both the internal policy as well as the member notification.	UniCare strives to ensure that there is meaningful access to the dental products and services for individuals with diverse culture and ethnic backgrounds. UniCare's customer service representatives are available to assist members. To help them better serve our customers, these representatives receive specialized training in areas such as service skills, problem-solving, our benefit plans, providing language translations services, and our provider networks. All network providers provide services in their own facilities, and are responsible for complying with all applicable laws.	Announcement_FED Mandated LEP and Nondiscrimination Taglines_CS_101716 Process for CS_LEP and Nondiscrimination Tagline Translation Requests.1… HCR EOB Language Insert Language Line Calls

12.	Describe the policies in place for addressing the health carrier's and providers' ability to meet the needs of covered persons, including, but not limited to children and adults, with serious chronic or complex conditions, including vision or hearing impaired. Attach both the internal policy as well as the member notification.	UniCare strives to ensure that there is meaningful access to the dental products and services for individuals with physical disabilities. UniCare customer service representatives are available to assist members. To help them better serve our customers, these representatives receive specialized training in areas such as service skills, problem-solving, our benefit plans. All network providers provide services in their own facilities, and are responsible for complying with all applicable laws. We do offer translating requested documented into larger font, braille, or audio CD by contacting Customer Service. Our primary method is to provide the information over the phone when speaking to the customer. Please see attached Provide Materials in Alternate Formats for Visually Impaired Members. UniCare Dental has (TTY/TDD) services available for the hearing impaired persons. The TDD/TTY operator contacts the customer service number given by the customer and identifies themselves as TDD/TTY interpreters. A three way conversation is set up. Associate communicates verbally with the TDD/TTY operator who communicates via the TDD/TTY phone with the speech/hearing impaired	Announcement_FED Mandated LEP and Nondiscrimination Taglines_CS_101716 Process for CS_LEP and Nondiscrimination Tagline Translation Requests.1… HCR EOB Language Insert Language Line Calls

		customer. Handicap accessible information is available on line via our Find A Doctor tool.	

13.	Describe the process in place for assessing the health care needs of covered persons and covered persons' satisfaction with the health care services provided. Describe how frequently these assessments are conducted. Confirm that there is a process in place to take corrective measures, when necessary.	UniCare has online resources providing advice on Dental health. UniCare tracks and measures health care needs and our consumer satisfaction with the Dental product and service we provide to our members through our Member Satisfaction Surveys. Call surveys are conducted on a daily basis and the mailed surveys are sent on a monthly basis. The selection process is done randomly using member calls, claims, and call transactions. Members are asked a series of questions that help determine their satisfaction with our product and services. Survey results are reported to company and department management on a semi-monthly basis for call surveys and mailed survey results are reported monthly. Our organization takes any form of dissatisfaction seriously, therefore, based on the results our team will reach out to members that request a call back to determine the root cause of their concern, following up as appropriate. Furthermore, UniCare leverages the Member Satisfaction trend and resulting analysis, in coordination with other resources, to continuously improve our member experience.	N/A

NETWORK ADEQUACY STANDARDS

	QUESTIONS	RESPONSES	NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND
1.	How many dental providers (as defined in §38a-478) does the health plan have per 1,200 covered persons? If the health plan does not have at least one provider per 1,200 covered persons, provide information on what corrective actions are being taken to address this and the date you expect to be compliant. (If you do not have any enrollment in the plan, indicate the total number of providers in your network.)	No Membership, 5,346 Dental providers	N/A
2.	How many general dentists does the health plan have per 2,000 covered persons? If the health plan does not have at least one general dentist per 2,000 covered persons, provide information on what corrective actions will be taken to address this and the date you expect to be compliant. (If you do not have any enrollment in the plan, indicate the total number of general dentists in your network.)	No membership, 4,058 General Dentists	N/A
3.	Verify that at least 70% of in-network providers accept new patients. Provide the actual percentage of providers in your network who accept new patients. If applicable, provide the answer by specialty. Describe how frequently this is measured, assessed and monitored.	All participating Dental providers are currently accepting patients. Providers are not permitted to close to new patients unless closing to all new patients including cash patients. We have not had any providers close to new patients.	N/A

4.	Describe the process in place for maintaining adequate arrangements to assure that covered persons have reasonable access to participating providers located near such covered persons' places of residence or employment.	Members can determine participation by checking the provider finder on our website or by contacting customer service at the number on their ID card we provided to them to determine participation in an area of interest. If UniCare were to have members in Dental 300, on a quarterly basis Anthem would review GEO reports to assess network adequacy. Anthem Blue Cross and Blue Shield ("Anthem") includes detailed information in our policies and certificates that explains nothing in Anthem's dental policies or certificates restricts the member from choosing a Dentist of their choice. Anthem includes a provision that outlines the process where there is no Participating Dentist available for the Covered Service, we may authorize the participating cost share amounts to apply to a claim for a Covered Service from a Non-Participating Dentist. Anthem instructs the Member to contact Customer Service for Authorized Services information or to request authorization. This Authorized Services provision is on page 17 of the dental policy submitted. (Example attached CT EXTRAS 102418 clean)	NDM Process Aid 26 Network Adequacy Monitoring CT EXTRAS 102418 clean page 17

		UniCare utilizes our affiliate network under Anthem BCBS.	
5.	Please fill out the actual maximum time and distance measures met for 90% of your members by county. Note: When measuring this data, include Connecticut-only members who reside in the state. Include all providers used for Connecticut service areas.	SEE "TIME & DISTANCE" standards on page 11 (Please provide the TIME & DISTANCE measures achieved for 90% of your members on page 11).	

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<tr><td>6.</td><td>Please see the timeframe requirements (in italics) for scheduling in-network appointments. Fill out the actual measure (in terms of hours for Urgent Care and days for everything else) that is achieved 90% of the time within your network for each provider type. If you are not compliant with the standards (in italics), indicate what measures have been taken to comply and when you expect to be compliant.</td><td colspan="2">APPOINTMENT WAIT TIMES<table><tr><th>TYPE OF APPOINTMENT</th><th>TIMEFRAME REQUIREMENT</th><th>TIMEFRAME ACHIEVED</th></tr><tr><td>Urgent care</td><td>Within 48 hours</td><td>19 hours</td></tr><tr><td>Non-Urgent appointments for general dentist</td><td>Within 10 business days</td><td>5 business days</td></tr><tr><td>Non-Urgent appointments for specialist care</td><td>Within 15 business days</td><td>6 business days</td></tr></table></td></tr>
<tr><td>7.</td><td>Confirm that a valid sample size, as defined by NAIC (95% confidence level with a 5% margin of error), was used to collect the appointment wait times reported.</td><td>Yes UniCare confirms a valid sample size was used to conduct scheduling in-network appointmets.

UniCare utilizes our affiliate network under Anthem BCBS.</td><td>N/A</td></tr>
<tr><td>8.</td><td>Describe the process in place to collect information regarding the average appointment wait times. How frequently is this information collected?</td><td>More than 90% of our providers are in all of our networks so we survey'ed the same set of providers for all networks.

On a quarterly basis access surveys are conducted by phone. Prospective offices are determined at random. Offices are called and asked the pertinent questions needed to obtain an answer for the mandated access requirements.</td><td>N/A</td></tr>
</table>

9.	Describe the health plans' efforts to ensure that covered persons have access to emergency dental services 24 hours a day, seven days a week.	When we conduct our provider survey's on timely access, we ask the provider about their running times for urgent, emergency appoints to identify if we need to have further conversations with the office if they are not providing times within the requirements. We have not had any providers we have surveyed to date provide time beyond the requirements. In addition, there is no way to identify when members have called a dentist directly for an emergency appointment to do a member survey of the time it took for them to get into the office from the time they called the provider. Today we take the word of the provider about how quickly they get the member in for treatment. Our Anthem BCBS PPO Provider Manual_2019 has the below language: Quality Assurance Timely Access to Care As an Anthem contracted Participating Dentist, you agreed to abide with the provisions of the Plan Quality Assurance Program including the approved accessibility standards. The Plan's access standards are as follows: Urgent Care: Within 48 Hours Non-Urgent appointments for general dentist: Within 10 business days Non-Urgent appointments for specialist	N/A

		care: Within 15 business days Providers are expected to reschedule a patient/members appointment in a manner that is appropriate to the patient/member dental care needs. Emergency appointments need to be available as necessitated by the patient/member dental condition. This requires that the dentist be on call 24 hours a day 7 days a week to assess the patient/member needs and determine when the patient/member should be seen. This availability requires the Anthem contracted Participating Dentist to use an answering service, telephone answering machine that is monitored for emergency telephone calls or other means of contacting the Anthem contracted Participating Dentist. When we conduct our provider survey's on timely access, we ask the provider about their running times for urgent, emergency appoints to identify if we need to have further conversations with the office if they are not providing times within the requirements. We have not had any providers we have surveyed to date provide time beyond the requirements. In addition, there is no way to identify when members have called a dentist directly for an emergency appointment to do a member survey of the time it took for them to get	

		into the office from the time they called the provider. Today we take the word of the provider about how quickly they get the member in for treatment. UniCare utilizes our affiliate network under Anthem BCBS.	
10.	Describe the process in place for monitoring on an ongoing basis the ability, clinical capacity and legal authority of participating providers to provide all covered benefits to covered persons.	The providers practice wihin the scope of their license, we verify the provider has an active license upon credentialing and re-credentialing. Our Credentialing Department monitors OIG, SAM, OMIG sanction reports along with license reports on a monthly basis to ensure providers are in good standing with their dental license to provide services to which we contract them to provide all covered benefits to our members. If a provider is on probation, suspended license that would lead to the conclusion that they are not qualified to provide covered services etc. they are removed from the network.	N/A

11.	Describe the process in place for ensuring that participating providers and facilities meet available and appropriate quality of care standards and provide high quality of care and health outcomes.	Anthem's Quality Improvement ("QI") Program is designed to ensure that quality care and services are delivered by focusing on the customers' needs within its care delivery continuum. We accomplish this by evaluating, monitoring, and implementing, when appropriate, an integrated process of QI activities designed to provide our customers with access to quality care and services. We define quality for the purposes of this program as meeting or exceeding customer needs and expectations while maintaining known requirements and standards. Anthem complies with all applicable federal or state law where we conduct business operations. Utilization management is under the clinical supervision of a licensed dentist (Anthem Dental Director). The UMC (Utilization Management Committee) goal (co-chaired by two state dental directors) is to create UM and clinical policies that support quality of care and good clinical outcomes. The Committee reviews oral health services and creates internal guidelines related to specific dental procedures for dental appropriateness by applying applicable evidence based clinical criteria and standards of care. In addition, a UM review of a claim assesses the benefit, cost and impact of oral health services for consumers, providers and group	N/A

		purchasers. Maintenance of clinical and UM policies includes annual updates directed at improving the oral health for members participating in all dental plans. UniCare utilizes our affiliate network under Anthem BCBS.	

12.	Describe the factors and standards used to build a network. Include a description of the network and the criteria used to select and tier health care providers and facilities, if applicable.	We want to make sure great care is accessible. That's why we work hard to have plan participating providers in the places we serve so that you can get the care you need, without any hassle. To help make sure you can find care, we consider the number of providers in your area, and how far you have to travel to a provider. Savings: We believe quality is just as important as affordability. We negotiate to keep pricing fair, with strong network discounts so our members can save on covered services. Also, when you use a network provider, you avoid balanced billing — which means you are only required to pay your copay for the covered service(s) you received. There may be higher costs to you if you visit a provider who is not in your plan's network. We recommend you contact the provider to confirm that they are in your plan network and that the desired service is covered. Important: While we make efforts to ensure that our lists of General Dentists and Specialists are up to date and accurate, providers do leave our networks from time to time, and these listings do change. There are General Dentists and Specialists or other providers who are not included in every plan network.	N/A

		Please make sure you are searching the right network. Logging in as a member is the most accurate method to search for providers in your plan network. You may also enter your alpha prefix (the first three letters of your member number on your ID card).	
13.	Provide a link to the carrier website where the standards used to build a network are posted in plain language.	https://www.unicare.com/health-insurance/nsecurepdf/English_common_pd_dental_doctors	N/A
14.	Explain how covered persons will be notified of contract termination, insolvency or other cessation of operations and transitioned to other participating providers in a timely manner.	Covered person will receive a letter from the Plan notifying them within 15 business days of receipt of provider termination. Letter will communicate member to contact Customer Service if they need assistance finding another in-network dentist. There is a process in place in the event of insolvency, provided by the guidance from the Connecticut Guaranty Association, indicating individuals would receive a notification from the liquidator and/or Connecticut Guaranty Association if the insurance company is found to be insolvent. We would coordinate accordingly.	N/A

15.	Describe the process for providing continuity of care to covered persons 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.	Once a provider termination notice is received, we review the Networks impacted, enter the network, date of receipt of notice, and effective date of termination. The information is ran through our automated process where members are notified within 15 business days of receipt of provider termination. Letter will communicate member to contact Customer Service if they need assistance finding another in-network dentist. UniCare utilizes our affiliate network under Anthem BCBS.	N/A

TIME (T) & DISTANCES (D) STANDARDS

SPECIALTY AREA	FAIFIELD COUNTY (Large Metro)	ALL OTHER COUNTIES (Metro)
Dental	30/15	45/30

TIME (T) & DISTANCES (D) TABLE

NETWORK ADEQUACY QUESTION #5: TIME (minutes) / DISTANCE (miles)							
FAIFIELD COUNTY	**HARTFORD COUNTY**	**LITCHFIELD COUNTY**	**MIDDLESEX COUNTY**	**NEW HAVEN COUNTY**	**NEW LONDON COUNTY**	**TOLLAND COUNTY**	**WINDHAM COUNTY**

No Membership	No Membership	No Membership	No Membership	No Membership	No Membership	No Membership	No Membership

PROVIDER DIRECTORY

QUESTIONS		RESPONSES
1.	Verify that a hard copy of the provider directory is updated at least annually and is available upon request. Provide the actual frequency of the hard copy directory updates.	Hard copies can be printed via online at anytime. The online directory is updated on a weekly basis. Our customers can contact customer service to request a provider directory and the agent will either email, fax, give names over the phone or mail a copy of the directory to the customer per their request.
2.	Verify that the online provider directory is updated at least monthly. Provide the actual frequency of the online directory updates.	Online Dental provider directory is updated weekly.
3.	Describe and provide a copy of the process in place to audit a reasonable sample size of the provider directory for accuracy. Indicate the frequency of such audits.	Verification of reasonable sample size is verified annually. Exceptions are: • Providers that have met initial credential in the last 12 months from the mail date are excluded from verification. • Providers contracted with a network that is not listed in the provider directory. Verification must be attested by the provider or authorized representative and includes date verified. Written verifications may be obtained by mail, fax, and email or on-line portal (if available). Phone verifications are accepted and date verified is tracked. Changes are updated in Provider Finder within 30 business days. Large Group verifications are conducted in accordance with Professional Services Policy & Procedure 13 which includes but not limited to extracting data for review and sending participation report to a Large Group for verification. A reasonable sample size is defined as: Confidence Level = 95% Error Rate = 5% Past Experience in error rate = 50% Size of Network.
4.	Provide a link to the online directory:	https://www.unicare.com/health-insurance/provider-directory/searchcriteria?brand=unicare
5.	Verify that the below requirements are met for both the online and the hard copy of the provider directory. Include a screen shot of an online and paper directory and indicate where each requirement is addressed.	

a.	The directory accessible to non-members.	Yes
b.	The directory clearly indicates the plan/network name(s).	Yes
c.	The directory clearly states when it was last updated.	Yes
d.	The directory clearly indicates whether a provider accepts new patients.	Yes
e.	The directory clearly indicates what other languages are spoken in the provider's office.	Yes
f.	The directory clearly indicates whether the provider's office is handicap accessible.	Yes
g.	The directory includes a description of the criteria the health carrier used to build its network.	Yes Our onnline directory includes this information. The printed directory is in process of being updated to include the language. Timeframe has yet to be communicated.
h.	If applicable, the directory includes a description of how the health carrier designates the different provider tiers in the network and clearly indicates the providers for each different tier of benefits.	N/A we do not tier.
i.	If applicable, the directory includes a statement that authorization or referral may be required to access some participating providers.	Yes
j.	The directory provides an e-mail address and a telephone number to report inaccurate information.	Yes

ATTACHMENT 1

THE FOLLOWING CERTIFICATION MUST BE COMPLETED AND SIGNED BY AN OFFICER OF THE COMPANY TO CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT

I, Click here to enter text. (PRINTED NAME), Click here to enter text. (TITLE)

of Click here to enter text. (COMPANY), hereby acknowledge that I have read the foregoing request and attached materials, that the information provided is true, accurate and offered in support of this request. I understand that any material changes in the information contained in this application must be filed with the Commissioner, as an amendment hereto, within thirty days of such change.

Click here to enter text.
(SIGNATURE)

Click here to enter text.
(DATE)