Connecticut Dental Practice Organization (d/b/a BeneCare Dental Plans)
Coverage Policy - Out-of-Network Services Coverage Exception
(Effective 1/1/2018)

Based on the extensive practitioner network maintained by Connecticut Dental Practice Organization, Inc. d/b/a BeneCare Dental Plans ("BeneCare"), there are very few situations in which a covered member will not have reasonable proximity and timely access to participating general and specialty practitioners, including ones accepting new patients.

Nevertheless, it may be possible that under rare circumstances, a Connecticut resident member of a fully insured BeneCare dental plan (a "Member") could be unable to obtain covered dental services from a participating practitioner without experiencing an unreasonable travel burden or delay. In those circumstances, Connecticut law requires BeneCare to allow the Member to receive services from a nonparticipating practitioner while having those services treated as in-network for the purposes of coverage and cost-sharing.

How the Provider Network Usually Works
BeneCare offers and administers network-based dental plans on behalf of its groups and Members. In these plans, participating practitioners (i.e. in-network dentists) enter agreements with BeneCare to accept the plan's payments plus applicable member cost-sharing as payment in full for covered services when treating Members. Participating practitioners cannot balance bill Members for covered services an amount above what they have agreed to accept. Members thus have limited, predictable cost share amounts for covered services received from a participating practitioner.

When a Member receives services from a non-participating practitioner (i.e. out-of-network dentist), there is no contract between the practitioner and BeneCare. Nonparticipating practitioners are therefore not bound by any agreement with BeneCare about how much they will charge for any particular services. This means the non-participating practitioner generally may balance bill Members for the difference between BeneCare's payment and the Practitioner's usual and customary charge.

There is a limited exception to the general approach described above when no participating provider is available to a Member without unreasonable travel or delay. In those cases, Connecticut resident members covered under fully insured dental plans ("Members") may request an "Out of Network Exception." Members who are approved for an Out of Network Exception may receive covered services from nonparticipating practitioners while being responsible for only in-network cost sharing levels.

Availability of the Out of Network Exception
The Out of Network Exception is available to Members (who are Connecticut residents and covered under a fully-insured BeneCare dental plan) when no participating practitioner is available to provide the Member covered services "without unreasonable travel or delay." In these

instances, BeneCare will apply in-network coverage and cost sharing rates to the services provided to the Member by out-of-network dentists.

BeneCare will recognize that a Member is facing "unreasonable travel or delay" in receiving covered services from a participating provider when**:**

1.) No participating practitioner is able to provide the covered service within 45 minutes and 30 miles from the Member's primary home address, or, **only for Members with a primary home address in Fairfield County,** within 30 minutes and 15 miles Member's primary home address; OR
2.) No participating practitioner who meets the travel standards described above has any appointment available to provide the covered services to the Member:
    a. within 10 days for general dentist care; or
    b. within 15 days for specialist care; or
    c. within 48 hours for urgent care; or
3.) No participating practitioner of the type required to provide a specific covered service is available; OR
4.) BeneCare's network of participating dentists does not otherwise satisfy the statutory adequacy standards required by the Connecticut Department of Insurance;

Regardless of whether or not an Out of Network Exception is authorized, all other terms of the member's policy and conditions of coverage remain in full force. In no event will this policy override any benefit limitations, annual or other maximum amounts, deductible applications or otherwise alter the schedule of benefits under a member's policy.

Requesting Out of Network Exception
A Member may request an Out of Network Exception before or after the services are rendered. When a Member believes covered services that have been, or are to be, provided to them qualify for an Out of Network Exception, the Member is responsible for informing BeneCare of that belief and requesting the Out of Network Exception.

If the Out of Network Exception request is made after the services are rendered, it can be made any time before (or contemporaneously with) the submission of the claim to allow the claim to process in accordance with the decision. An Out of Network Exception may also be made after the claim is adjudicated; in that case, the request should be made in the form of an appeal under BeneCare's appeals process. In that event, if an Out of Network Exception is granted, the claim would subsequently be adjusted accordingly.

Alternatively, a Member may request that BeneCare confirm their eligibility for an Out of Network Exception prior to receiving services. The Member must provide all information needed by BeneCare in order to evaluate the request. BeneCare will not process the request prior to receiving any information requested and reasonably necessary to evaluate the Member's eligibility for an Out of Network Exception.

Any advance confirmation of an Out of Network Exception is necessarily subject to certain limitations, including but not limited to, such confirmation extending only to those services:

- which are, or which are necessarily delivered incident to, services for which no participating practitioner was reasonably available to the Member without "unreasonable travel or delay";
- which are delivered within a reasonable amount of time after the advance confirmation is issued; which are otherwise covered services under the Member's plan.

An advance confirmation of the availability of an Out of Network Exception is not a guarantee of reimbursement in accordance with this policy. All claims for reimbursement are subject to the terms of the Member's plan. BeneCare has no responsibility for services which are not covered under the Member's plan. Additionally, if the Out of Network Exception was inapplicable to the services when rendered for the reasons described above or any other reason, reimbursement for the services would be processed in accordance with the Member's out of network benefit, if any, and may include balance billing.

Evaluating the Request for an Out of Network Exception

BeneCare will not evaluate the availability of the Out of Network Exception for services unless a Member requests that evaluation. BeneCare, in its discretion, may require the Member to provide substantiation of the facts that support their request. Such substantiation may include, but not be limited to, evidence of their claimed home address (if different from their address of record with BeneCare), a list of the participating practitioners the Member contacted when attempting to make a timely appointment (if claiming unavailability of appointments), or substantiation of the clinical necessity of a specialist (if claiming lack of availability of a particular type of dental specialist). If BeneCare cannot determine whether the Out of Network Exception is available due to a Member's failure to provide reasonably requested substantiation, the request will be denied.

BeneCare will review the Member's request and any available documentation. At BeneCare's discretion, it may conduct its own reasonable fact finding regarding the availability of participating practitioners. BeneCare will make reasonable efforts to determine whether the Out of Network Exception is available. BeneCare will then document its decision regarding its payment to the non-participating practitioner and give notice to the Member and, when appropriate, the treating practitioner.

BeneCare will respond to a Member's request in a timely fashion appropriate to the Member's condition. A response to the member's request will be issued within five (5) business days of receiving all the information necessary to evaluate the request. For urgent care services requiring expedited review where the request is made prior to the provision of such services, a determination will be issued within seventy-two (72) hours of receiving all the information necessary to evaluate the request.

Treatment of Claims when an Out of Network Exception is Approved

When a Member's request for an Out of Network Exception is approved pursuant to this policy, that Member shall receive the same benefit (including the same in-network cost-sharing) for those covered services provided by a nonparticipating practitioner as the Member would have received had services been rendered by a participating practitioner. The Member will be required to pay the same amount that a Member would have paid to receive the covered service had the treating practitioner been a network participant. BeneCare shall either pay the out-of-network dentist's charge or negotiate a payment with the dentist that holds the Member harmless from any balance billing for covered services. The amount paid that exceeds the amount BeneCare would have paid for the covered benefit shall not apply to the Member's annual maximum for the procedure(s), if applicable.

This policy shall not apply where a Member elects to receive covered services from a non-participating practitioner based on the Member's own decision and the criteria described above have not been satisfied. This policy shall also not apply to Members enrolled in a self-funded plan governed by federal law.

This policy shall be effective January 1, 2018, and shall remain in effect until terminated or otherwise changed, consistent with applicable law and regulations.