PPO Network Access Plan

Colonial Life, Starmount and AlwaysCare Benefits, Inc. are subsidiary companies which operate under the insurance holding company Unum Group (the Company). Starmount is an independent provider of dental and vision insurance in the United States, and AlwaysCare Benefits, Inc. is a nationally licensed third-party administrator.

Network Composition

To the greatest extent attainable, the Company maintains an extensive dental and vision in-network participating provider panel in all service areas. In the same manner, the Company ensures that covered persons can obtain services without an unreasonable delay and within proximity to an in-network participating provider, according to adequacy and accessibility standards.

VISION: Our national network includes independent optometrists, ophthalmologists, opticals and retail stores like Walmart Optical, America's Best Contacts & Eyeglasses, and Target Optical.

Vision services covered by our vision plans (routine exam to screen for disease and evaluate vision acuity for necessary vision correction) can be supported by Optometrists and do not necessarily require the services of an Ophthalmologist. When members nominate an Ophthalmologist for our panel, we recruit them as an accommodation to the member and to help prevent disruption.

DENTAL: Our national dental network is comprised of both leased network arrangements and our own proprietary dental network to expand the network and maximize the available participating providers to our members.

Participating network providers have agreed to certain fee schedules. Members that seek services from in-network participating providers will generally incur less out-of-pocket costs.

Provider Criteria

Our network of participating providers has been rigorously reviewed for competency, and contracted to follow specified guidelines. Each provider must meet our credentialing standards, at a minimum, meet the NCQA standards or other similar industry acceptable organization's standards, established nationwide, as applicable to the specific type of provider and benefit plan.

Network Monitoring and Maintenance

The number of members and providers are tracked throughout the year. We use enrollment data to generate Geographic Access reports regularly and review the reports to determine areas that may need additional providers.

When service areas are identified where there are members without access to a participating provider within the applicable access standard, we determine the reason that covered services are not available through the existing provider network. For example, covered services are not available through the existing provider network due to a lack of providers in the noted areas or, in areas with a provider presence; the local providers were not amenable to contracting with the network. In those areas where there is no established reason for the lack of access, a network development campaign is initiated with the intent of achieving the required access.

In addition, either during the evaluation period by a potential client or implementation of a new client program, upon request we will provide reports to determine network access. The types of reports available include:

1. Geographical Access report using the client's zip code listing of its enrollment data.
2. Disruption report using the client's previous claims activity.
3. Provider Directory for any requested geographical area(s). The provider directory is available to the public online, twenty-four hours a day, seven days a week. A print copy is available, within five business days, upon request by calling Customer Service at (888) 724-5433.

The adequacy of the Company's panel to provide services to the client's members is assessed and opportunities, to the extent appropriate, for supplementation of the Company's panel are identified. The telehealth is not used to meet healthcare needs and network adequacy standards. When such areas are identified, the Company initiates a network development campaign to secure the participation of the providers deemed necessary by the Company and the client. We actively work with clients and providers to address issues pertaining to accessibility to services and appointment wait times for both new and established patients.

Individual providers are also contacted on an ad hoc basis to request network participation when requested by future or current members.

Network Adequacy and Accessibility Standards

Because we do business across many different jurisdictions and because state and/or federal regulations generally require network accessibility standards specific to a certain jurisdiction and/or line of business, we do not have a single set of network accessibility standards. Rather, we adopt the accessibility standards applicable to each of the jurisdictions and lines of business it manages to meet the needs of its clients and recruits its providers in order to meet the accessibility needs of those clients.

Choice of Providers

Referral Process

Members may seek covered services from an in-network or out-of-network provider without a pre-authorization or referral.

General Plan for Providing Services

Members have the option to use participating providers that offer services according to their contracted fee schedule. Members are also allowed the opportunity to use any out of network provider at all times.

If a member is unable to obtain services from an In-network provider due to the network being inadequate in their area, the member should contact a Customer Service Representative, (888) 724-5433 to seek instructions regarding a visit to an out-of-network providers when the network is not adequate.

Communication

Each named subscriber is issued a Certificate of Coverage or Policy, which includes a Schedule of Benefits for their selected plan. Members may register for online access to AlwaysAssist www.alwaysassist.com, an online tool designed to assist the member with locating providers, printing ID cards, printing benefit summaries, checking claim status, contacting Customer Service, managing claim privacy and accessing certain forms.

Telehealth Services

Our members have the freedom to select from in and out-of-network providers. They may also choose the type of provider they use. We contract providers who meet several criteria, including requirements of meeting standard of care, meeting the rules and regulations of their jurisdiction, complying with HIPAA, and meeting credentialing requirements.

Coverage for services delivered via telehealth modalities will be at the same levels as those services provided through in-person encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed in the state where the patient receives service.

Patients with Special Needs

We are committed to providing equal access to services to insureds with physical and visual disabilities as to insureds without such disabilities. We are also committed to assisting in the coordination of care for insureds who are minors and require the involvement of a parent, guardian or other individual in making decisions concerning the minor's care. We also assist in the coordination of care for adult insureds who have instructed their provider by means of an advance directive for the provision or withholding of dental or vision care or the designation of another individual to make treatment decisions on the insured's behalf, if the insured is or becomes unable to make their own decisions.

Our providers are required to comply with all local, state and federal laws and regulations that relate to the provisions of dental or vision care services, including applicable requirements of laws prohibiting discrimination based on disabilities, including the Americans With Disabilities Act.

It is our policy to make arrangements as necessary to accommodate those insureds who have special needs to ensure that they have equal access to administrative and clinical services on the same basis as do insureds who do not have special needs.

Non-English speaking

We offer interpreter services for non-English speaking members. Our service interprets over 180 languages and dialects. If you require language assistance, please contact our Customer Service Department at 888-729-5433 ext 2013 to be connected to an interpreter.

In the event of a call to our Member Services call center from a Non-English speaking caller, the Member Services representative initiates a conference call to Language Line and either requests assistance with the language needed, if the representative has been able to determine the language, or assistance with determining the language needed, if the representative has been unable to determine this.

Hearing impairment

We utilize a TTY line for communication with individuals who are hearing-impaired. Insureds may initiate a call through the TTY by calling a toll-free number or, in the event a call is received from a hearing-impaired individual on our standard Member Services line, the Member Services representative initiates a call to the TTY Service.

Minors and Mental, Physical, and Visual Disabilities

Accordingly, to the extent a minor insured requires special accommodation, or an adult insured requires special accommodation based upon a mental, physical or visual disability and such accommodation is not normally available within a participating provider's office, we will make the necessary arrangements to ensure equal access to care. Due to varying individual needs, the nature of such arrangements is determined on a case-by-case basis pursuant to the special need identified. Such arrangements may include allowing an insured to receive services from a non-participating provider as appropriate to the situation and within the benefits provided in the Certificate of Insurance.

Other Special Needs

While the specific circumstances referenced above represent a majority of special needs that we have experienced, we recognize that insureds face many special needs, many of which cannot be foreseen and planned for. As we, our clients, and our participating providers identify insureds with special needs not previously addressed in this procedure, we will make such arrangements as are

necessary to provide equal access to administrative and vision/dental care services as are provided to insureds who do not have special needs. Due to varying individual needs, the nature of such arrangements is determined on a case-by-case basis pursuant to the special need identified. Such arrangements may include allowing an insured to receive services from a non-participating provider, as appropriate to the situation and within the benefits provided in the Certificate of Insurance.

In the unlikely event that we are unable to make arrangements to address the special need that are satisfactory to the insured, we will notify the policyholder through which the insured is enrolled in order to determine the appropriate accommodation.

Non-discrimination

All of our Member Services representatives are trained with regard to the procedures for facilitating calls as referenced above so that these calls are handled professionally and efficiently. All representatives are also trained to process all calls with regard to special needs members in a professional and courteous manner and to treat all special needs members with the same level of professionalism, respect and courtesy as is afforded to insureds who do not have special needs including those with diverse cultural and ethnic backgrounds.

Our representatives are further trained that no insured with special needs is to be denied access to information or vision/dental care services. In the event a representative is uncertain how to handle a certain request for special needs services, the representative is trained to bring the matter to the attention of the Member Services supervisor or director for further assistance in addressing the special need.

Confidentiality

Our staff is trained to execute all duties, including those related to insureds with special needs, with utmost regard given to protecting the confidentiality of any protected health information which comes to the staff member's attention in the process of executing their duties. The process followed for ensuring access to administrative and clinical services for insureds with special needs follows our Privacy Policies, which comply with HIPAA requirements.

Grievance and Appeal Procedures

If payment for any service or part of a service has been denied and you do not agree with the denial, you can call us at 888-400-9304 to discuss this claim for benefits. You also have the right to file a grievance and written request for review concerning any denied or partially denied claim and any precertification request that has been denied. Grievances must be filed within 60 days of your receipt of this notice.

To initiate the grievance process, you may:

- Visit our website, [alwaysassist.com], for a copy of the Grievance Form,
- Call us at 888-400-9304 and ask for a Request for Review/Grievance Form, or
- Write a letter to “Grievance Coordinator” at P.O. Drawer 98100, Baton Rouge, LA 70898-
- 9100, and plainly state the reason(s) for your grievance.

All written requests must include any additional information you may have regarding your claim for benefits.

You will receive written notice of the decision on your grievance. This notice will cite the specific reasons for the decision. The decision shall be made no later than 30 calendar days after receipt unless we have notified you in writing that we require an additional 30 days to review your grievance.

Unless your policy or certificate of coverage states otherwise, grievances regarding urgent care shall be resolved within 4 days of receipt.

If you are not satisfied with the response to your grievance, you have the right to request additional levels of review. Any such requests must be made in writing within **30 days** of the date after you receive adverse determination to the prior level of review.

If your health plan is sponsored by your employer, subject to ERISA and your grievance results in adverse determination, you have the right to bring a civil action under 502(a) of ERISA. However, you must file a written grievance to us which results in an adverse determination prior to exercising this right.

Reconsideration

When rendering an adverse dental recommendation, we or our dental consultants must provide the provider or the insured with an opportunity to seek a reconsideration of that recommendation. A reconsideration is a verbal or written request or inquiry by a provider or insured regarding an adverse decision.

Procedure

We or the provider may make a request for reconsideration to our dental consultants in writing or by phone.

The original recommendation file is retrieved and claims consultant that conducted the initial review of the claim will not be involved in any further review or benefit determinations.

The new claim consultant will speak one on one with the provider and will exchange information by telephone, fax or otherwise, as needed and based upon the discussion and additional information. The consultant will make a decision regarding whether the recommendation will remain the same or whether, based upon the additional information provided, our dental consultants will instead recommend that services be authorized or benefits paid.

Coordination and Continuity of Care Provisions

A covered person who is in an active course of treatment may be transitioned to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.

Transition Procedures

A covered person may request continuity of care by contacting our Customer Service department by phone, fax or mail. All requests received by Customer Service will be sent to Director of Claims for evaluation, decision and transition plan development.

Director of Claims will send all received requests to Medical Director, along with the covered person's applicable claim history.

Medical Director will consult with the treating provider. After consulting with the treating provider, Medical Director will grant or deny the request.

An attempt to notify the covered person of the decision by telephone shall be made and documented in the Customer Service database. Whether the telephone attempt is successful or not, the covered person shall be notified of the decision in writing. The written notification shall include the grievance and appeal rights and process.

The provider who departed or terminated from the network may provide the continuity of care services only when the provider:

- Was not removed or left the network for cause.
- Agrees in writing to accept the same payment from and abide by the same terms and conditions in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier.
- Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.
- The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider is extended to provide continuity of care for the covered person.

If the previous provider does not meet all of the outlined conditions, and the covered person has not already selected a new participating provider, the covered person will be sent a current list of participating providers who accept new patients in their same geographical area. The list will include the provider's specialty. A participating provider will be selected from the list and the Medical Director will work with the chosen provider to provide continuity of care for the covered person.

Eligibility

The covered person must have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.

Conditions that are not covered due to a pre-existing condition exclusion may be excluded from continuity of care provisions.

Continuity of Care decisions are subject to the plan's internal and external grievance and appeal processes in accordance with applicable state and federal laws and regulations.

Continuity of Care Period

The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

- The termination of the course of treatment by the covered person or the treating provider;
- Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical Director determines that a longer period is necessary;
- The date that care is successfully transitioned to a participating provider;
- Benefit limitations under the plan are met or exceeded;
- The date that the coverage is terminated; or
- The care is no longer medically necessary.

Most Recent Review/Revision	Applicability	Type
January 2019	*All States*[1]	*Dental & Vision*

[1]The policies included in this document are applicable in all states. State specific policies are available when the state's requirements are stricter than what is included in this policy. Contact our Customer Service Department at (888) 724-5433 to request a policy for a specific state.