NETWORK ACCESS PLAN

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NETWORK ACCESS

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 and, 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:

- Geographical Access report using the client's zip code listing of its enrollment data.

- Disruption report using the client's previous claims activity.
- 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) 400-9304.

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. 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 recruit 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 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 Customer Service, (888) 400-9304to seek instructions regarding a visit to an out-of-network provider 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.

GRIEVANCE & APPEALS

If a Member has a grievance or would like to appeal a claim, they may submit it to us verbally or in writing. We have policies and procedures in place to resolve it in a timely manner based on urgency and state regulatory requirements. It is imperative all requested information (such as x-rays and patient records) is submitted as soon as possible. Failure to submit complete information may impact our ability to meet deadlines and could negatively affect the final conclusion. All grievances and appeals are properly documented, and our responses will be provided and communicated to the Member as required by federal and state law.

To initiate a grievance or appeal, please:

- Contact us at 888-400-9304; or
- Submit in writing with the reason for the grievance/appeal and sufficient information to identify the Member to: Grievance Coordinator, P.O. Drawer 98100, Baton Rouge, LA 70898-9100

Grievance and appeal information is also on our website, and on the Explanation of Benefits (EOB) Members receive after claims are processed.

CONTINUITY OF CARE

Our Members who are in an active course of treatment may be eligible to transition to a participating provider in a manner that provides for continuity of care when their provider leaves or is removed from the network.

To request continuity of care, or request a copy of our policy, contact our Customer Service department by phone at 888-400-9304 or by mail to P.O. Drawer 98100, Baton Rouge, LA 70898-9100.

MEMBERS WITH SPECIAL NEEDS

We are committed to providing equal access to services to Members with physical and visual disabilities as to Members without such disabilities. We also strive to lead by example and provide websites that are accessible to all audiences, regardless of technology or ability.

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 plan as necessary to accommodate those Members who have special needs to ensure that they have equal access to administrative and clinical services on the same basis as do Members 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 language assistance is required, please contact Customer Service at 888-400-9304 to be connected to an interpreter.

In the event of a call to Customer Service from a Non-English speaking caller, the representative initiates a conference call to the interpreter service 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. Members 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 by Customer Service, the representative initiates a call to the TTY Service.

Minors and Mental, Physical, And Visual Disabilities

Accordingly, to the extent a minor Member requires special accommodation, or an adult Member 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 a Member to receive services from a non- participating provider as appropriate to the situation and within the benefits provided in the Policy or Certificate of Coverage.

We will assist the coordination of care for Members 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 Members 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 Member's behalf, if the Member is or becomes unable to make their own decisions.

Other Special Needs

While the specific circumstances referenced above represent a majority of special needs that we have experienced, we recognize that Members face many special needs, many of which cannot be foreseen and planned for. As we, our clients, and our participating providers identify Members 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 Members 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 a Member to receive services from a non-participating provider, as appropriate to the situation and within the benefits provided by the Policy or Certificate of Coverage.

Non-Discrimination

All of our Customer Service 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 Members who do not have special needs including those with diverse cultural and ethnic backgrounds.

Our representatives are further trained that no Member 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 Members with special needs, with the 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 Members with special needs follows our Privacy Policies, which comply with HIPAA requirements and Appeal Procedures.

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) 400-9304 to request a policy for a specific state.