Required State Notice – CT Network Adequacy Information

How to Build a Network

Our dental network (Commercial, Medicare and Medicaid) consists of general dentists, periodontists, orthodontists, oral surgeons, endodontists, pediatric dentists and prosthodontists. To help provide members with required access to providers we review the number of contracted providers and the types of services offered within a geographic area as well as the member/provider ratios. We also collect information such as handicap accessibility, languages spoken and office hours.

Dental Benefit Providers, Inc. (DBP) reviews provider access and availability annually to ensure that members have an adequate network of providers to meet their needs. Results are shared with appropriate committees and workgroups for further analysis and identification of opportunities for improvement. We continue to monitor the adequacy and availability of our current complement of network providers and will undertake any supplemental contracting with all provider types that is necessary to ensure continued appropriate access.

Prospective providers are identified from available competitor data, out of network claim submission data, and member and provider nomination requests. We are also committed to ongoing research for any/all viable provider recruitment candidates. When additional providers are identified and determined to be viable recruitment candidates, we will outreach to those providers to determine their interest in participation.

DBP will negotiate rates for treatment with any available out-of-network provider for members without access on a caseby-case basis and ensure that members are held harmless from "balance-billing" or any amounts beyond the copayment, deductible, and coinsurance percentage that we would have paid had the insured received services from an in-network provider.

Network Provider Quality

All providers who are part of our network must complete our credential verification process before acceptance into the network. Initial Credentialing includes detailed review to determine that:

- A provider's education and experience are adequate and appropriate for the services he or she provides;
- A provider's license(s) are appropriate and up-to-date;
- The provider maintains adequate malpractice insurance;
- The provider is in good standing with the State Dental Board and Medicare/Medicaid programs with no substantive complaints, probation or sanctions filed against him or her; and
- Initial Site Visit review score, if applicable, falls within Quality Management standards.

Re-credentialing must be conducted no later than three years from the original credentialing date, and at least every three years thereafter, according to State, Federal and contractual requirements. All credentialed providers are subject to Continuous Credentialing, whereby changes in a provider's credentialing data may be reviewed at any time in order to determine that the provider continues to meet credentialing standards. The Credentialing Department, along with the Credentials Verification Organization (CVO), will monitor twice a month, including, but not limited to, the following items: sanctions on licensure, Medicare/Medicaid sanctions, and complaints/grievances.

Access Standards

Providers must comply with our policies and each state's mandated requirements that include, but are not limited to:

- Availability & Accessibility regarding time and distance standards
- Appointment Wait Times to get into see a provider

CT State-Specific Standards

Availability and Accessibility Time and Distance Standards:

- Fairfield County 30 minutes and 15 miles
- All other Counties 45 minutes and 30 miles

Appointment Wait Times:

- Urgent Care within 48 hours
- Non-Urgent Appointments for General Dentist within 10 business days
- Non-Urgent Appointments for Specialist Care within 15 business days

Cultural Competency

Provide services in a culturally competent manner. This includes handling members with limited English proficiency or reading skills, diverse backgrounds and physical or mental disabilities.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.