Frequently Asked Questions about 2016 Health Benefit Plans: UnitedHealthcare Charter, Compass, Core and Navigate

Background
UnitedHealthcare has developed consumer-focused benefit plans to meet member requests for affordable health care options. In response to these growing needs, we are pleased to introduce UnitedHealthcare Compass (Individual Exchange benefit plans) and the UnitedHealthcare Charter, Core and Navigate benefit plans. We created more focused networks that are tailored to local market needs, so the new benefit plans may not be available in all states and you may not be a participating care provider for all benefit plans.

Provider Network

Q1. How do I know if I am a network provider for these benefit plans?
A. If you participate in other UnitedHealthcare commercial benefit plans, you are considered a network provider for UnitedHealthcare Compass, Charter, Core or Navigate benefit plans if offered in your market, unless these plans are specifically excluded in your participation agreement. You will also be listed in our provider directory for each benefit plan. Be sure to confirm your participation status while verifying patient eligibility and benefits.

For Compass, your practice must be located within the defined Compass network service area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. You can reference Compass network service area maps on UnitedHealthcareOnline.com > Tools & Resources > Products & Services > UnitedHealthcare Compass.

Q2. Can my participation status vary by product?
A. Yes, not all providers will be part of these networks or included in every network. UnitedHealthcare is creating more focused networks to meet member requests for additional options at affordable prices.

Q3. Do these health plans use the same network as UnitedHealthcare Choice/Choice Plus?
A. No. UnitedHealthcare is building new Commercial benefit plan designs with customized network configurations to meet member needs for access to coordinated care and greater affordability. Because our networks are built at the local market level, these plans offer tailored networks of care providers that may vary by product. To find network providers, including hospitals and independent labs, refer to the provider directory at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory.

Q4. How do practice administrators search for physicians, facilities or other health care professionals who participate in the network?
A.

1. Go to UnitedHealthcareOnline.com > Physician Directory > General Physician Directory
2. Select the member's benefit plan. For Charter, Compass and Navigate, select the HMO licensed products if the member's ID card lists, "UnitedHealthcare of [State]" in the bottom right corner. Otherwise, select the name of the member's benefit plan as identified in the bottom right corner of the ID card.

3. Search for a physician by name, specialty and/or condition.
4. Narrow the search by zip code.

When a member searches for a care provider on myuhc.com, the only names that appear are physicians and care providers who participate in the member's network.

Q5. Which health plans require referrals and offer out-of-network physician coverage?
A.

Health Plan Name	Benefit Level	Network physician with prior referral	Network physician without prior referral	Out-of-Network Physician
Charter Compass Navigate	Network only benefits	Network benefits	No coverage*	No coverage, except for emergency care*
Charter Balanced, Compass Balanced, Navigate Balanced	Network only, with lower out-of-network benefits	Network benefits	Lower level benefits	No coverage, except for emergency care*
Charter Plus, Compass Plus, Navigate Plus	Network only, with lower out-of-network benefits	Network benefits	Lower level benefits	Lower out-of-network benefits

**Member is responsible for the billed amount (subject to exceptions for which applicable law does not allow a referral requirement).*

UnitedHealthcare Core does not require referrals.

Health Plan Name	Benefit Level
Core	Network, with out-of-network benefits
Core Essential	Network Only (no out-of-network benefits)

Primary Care Physician Selection – Charter, Compass and Navigate only

Q6. Do members have to select a Primary Care Physician (PCP)?
A. Yes, each member in a Charter, Compass or Navigate benefit plan must choose a PCP* to assist with their health care needs and obtain referrals to see network specialists. If a member does not choose a PCP during open enrollment, one will be assigned to them. The assigned PCP and their phone number are listed on the front of the member's ID card.
** Physicians who are part of a leased network may not be selected; please refer to the provider directory to confirm participation.*

Q7. If a PCP practices at more than one location, does it matter which location the member visits?
A. Since some PCPs have multiple tax ID numbers that may not all participate for the member's benefit plan, members are required to see their PCP or a covering physician at an address location that shares the same tax ID number listed on the member's profile, under the Patient Eligibility screen.

Prior to scheduling appointments, be sure to verify that you are the member's assigned PCP and the tax ID number listed on the Patient Eligibility screen is the same tax ID number for the address location where you will see the member. You may submit corrections through

UnitedHealthcareOnline.com or call the phone number on the back of the member's ID card prior to seeing the member.

Q8. How can I obtain a list of members assigned to my practice?

A. PCPs may self-report this information using UnitedHealthcareOnline.com. For step-by-step instructions on accessing these reports, please go to UnitedHealthcareOnline.com > Help > Quick Reference > Reports Quick Reference.

Specialist Referral Requirement – Charter, Compass and Navigate only

Q9. Who is responsible for generating referrals?

A. For members in Charter, Compass and Navigate benefit plans, the member's PCP coordinates the member's care and generates referrals to network specialists. Referrals must be in place prior to the member seeking care with any network physician that is not practicing under the same TIN as the PCP. If the PCP does not follow referral requirements, the member may face financial penalties.

Q10. What services require a referral?

A. Referrals are required if a member needs to seek care from certain network specialists when UnitedHealthcare is the primary or secondary payer. Some network specialist services do not require referrals.

Services that do not require a referral:

- Services for physicians with the same Tax ID as the member's PCP.
- Hospital-based physicians (i.e. pathology, radiology, anesthesiology).
- Non-physician type services:
  - Any outpatient lab, x-ray or diagnostics
  - Physical therapy, rehab services with the exception of manipulative treatment and vision therapy (e.g. physician services)
  - Durable medical equipment, home health services, prosthetic devices, hearing aids
- Services from participating obstetricians/gynecologists
- Routine refractive eye exams from participating physicians
- Mental health/substance use disorder services with participating behavioral health clinicians
- Services rendered in any emergency room or network urgent care center or urgent care provided at a convenience clinic
- Physician services for emergency/unscheduled admissions
- Any services from inpatient consulting physicians
- Any other services for which applicable law does not allow a referral requirement
  - AZ, KY, MO, WA, WI, GA= Chiropractor (up to 26 visits for MO only)
  - AR, CO, GA = Optometrist and Ophthalmologist
  - GA = Dermatologist
  - AL = Optometrist
  - FL = Chiropractor, Podiatrist, Dermatologist (5 visits)

For more information about UnitedHealthcare Commercial plans, please refer to the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols & Guides.

Q11. Can members seek care outside the state in which they live?

A. Members may be referred to a network provider located in another state when standard protocols are followed. In some cases, members have in-network coverage only and therefore will not have coverage if services are received by a non-participating provider.

Some health plans offer a limited network of care providers, including hospitals. To find a network provider, always reference the online provider directory for the most current information.

Q12. What if a member requires care not available from a network specialist or facility?

A. When services are not available from a network physician or facility, the member's PCP can request services by a non-network provider at the in-network benefit level. The member's physician may request the exception by calling the number on the back of the member's ID card. UnitedHealthcare will review the request and determine whether a care provider in the member's network is available to treat their condition and whether the request should be approved to cover eligible services at the in-network level. We will send written confirmation of the final decision to the requesting physician and the member.

<u>Before submitting a request for an exception:</u>

1. Confirm there is no network provider available by searching the provider directory.
2. If there is not a network provider available, determine if the member has the W500 Additional Network Benefit (see Q13 for more information) by reviewing the member's ID card.
    a. If W500 is indicated on the member's ID card, search for a network provider in the W500 Additional Network directory.
    To access the W500 Additional Network directory:
        i. Select Physician Directory > General Physician Directory
        ii. Select the member's benefit plan
        iii. Select W500 Additional Network directory
        iv. If a network provider is found, then request an exception for the member to see the network provider participating for the W500 Additional Network.
    b. If W500 is not indicated on the member's ID card, or if a network provider is not found in the W500 Additional Network Directory, proceed with submitting a request for a non-network provider.

Q13. What is the W500 Additional Network Benefit?

A. Some benefit plans include additional network benefits for certain services provided through an alternate care provider network. These services include:

- Emergency services and related admissions
- Urgent care services
- Preapproved services by UnitedHealthcare when services are not available from a network physician

The W500 Additional Network benefit plan is comprised of care providers in a limited service area, who are otherwise excluded from participation in that plan. Providers who have been excluded from participation may be contracted for W500 to provide coverage for certain services at an in- network benefit level.

Q14. How many visits are included with each referral to a specialist?

A. Each referral may include up to six visits. Any unused visits expire after six months from the date the referral was entered. After the six visits are used or expire, the PCP may submit another referral to the network specialist for up to six visits.

For members with certain chronic conditions, the online referral screen allows standing referrals to be entered for 99 visits if the member's diagnosis code is included in the Referrals for Chronic Conditions policy on UnitedHealthcareOnline.com.

Chronic conditions eligible for standing referrals of up to 99 visits

ICD-9 Code	Diagnosis
042X	AIDS/HIV
280-289.X, 773.0, 773.1, 776.5	Anemia
140X- 208X & 230 - 239.9	Cancer
277.00; 277.01; 277.02; 277.03; 277.09	Cystic Fibrosis
332.0; 332.1	Parkinson's Disease
335.2X	Amyotrophic Lateral Sclerosis
340	Multiple Sclerosis
345.0 – 345.9X	Epileptic seizure
358.0	Myasthenia Gravis
365 – 365.9X	Glaucoma
446.6	Thrombotic Microangiopathy
477X	Allergies
584.X	Renal failure (acute)
780.39	Seizure
800 – 829.X, 733.8X	Fracture care* *****It is not necessary to specify the fracture care procedure performed on the referral.

Q15. Can referrals be viewed online?

A. Yes. You may securely view a member's inventory of referrals on the Referral Status Detail screen on UnitedHealthcareOnline.com. Information includes the network specialist the member is referred to, number of visits authorized and the number of visits remaining.

Q16. Do specialists and facilities have to confirm a referral is on file from the member's PCP before seeing the member?

A. Yes. Specialists must confirm a referral is on file prior to seeing the member. The information also determines member benefits, since some plans either have no benefit or higher member cost share if a referral is not obtained. Facilities should also confirm the referral is on file for the admitting specialist for planned admissions. If the member does not have a referral to see the specialist for planned admissions, then the facility and specialist claims will be denied for no referral. For more information on how to get status on referrals, please see UnitedHealthcareOnline.com > Help > Quick Reference > Notifications/Prior Authorizations > Referral Status Quick Reference.

Q17. What if a member needs to see another specialist, or return for additional visits after the referral has expired, or if all visits have been used?

A. In each case, the member's PCP must be contacted to consider an additional referral.

Referral Submission Requirements – Charter, Compass and Navigate only

Q18. How do PCPs submit specialist referrals?

A. For members in Charter, Compass and Navigate benefit plans, PCPs must submit referrals on our secure website before the specialist service is performed at. The referral is effective immediately and will be viewable online within 48 hours.

Referrals cannot be accepted by phone, fax or paper, unless required by state law. Referrals may be entered on UnitedHealthcareOnline.com with a referral start date up to five calendar days prior to the date of entry. For more information on how to submit referrals, go to UnitedHealthcareOnline.com > Help > Quick Reference > Referral Submission and Status.

Q19. Does my office staff need specific access to UnitedHealthcareOnline.com to submit and view referrals on file for members?

A. Yes. If you have assigned the pre-defined role type, "All Transactions on UnitedHealthcareOnline.com" for your staff, they will have access to submit and view referrals for members. If your practice has customized roles, be sure the appropriate staff members in your practice have the "Referral Submission Role" and/or the "Referral Status Role." For more information on access and roles, go to UnitedHealthcareOnline.com > Help > Quick Reference > Referral Submission and Status.

Q20. How do I register for UnitedHealthcareOnline.com if I do not have access today?

A. Visit UnitedHealthcareOnline.com, click "New User" in the upper right corner and follow the prompts. If you have questions, please call 866-842-3278 (866-UHC-FAST), option 2.

Advance Notification / Prior Authorization

Q21. Do these health plans require advance notification or prior authorization?

A. Advance notification and prior authorization is required for certain planned services so we can determine if the services are covered under the member's benefits. Prior authorization is granted only for services determined to be medically necessary according to the member's benefit plan and applicable policies and guidelines.

The Notification Requirements section of the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("Administrative Guide") covers protocols about services requiring advance notification and prior authorization and the process for providing advance notification. It is the physician's responsibility to follow the advance notification or prior authorization procedures as outlined in the Administrative Guide.

Q22. Is admission notification required?

A. Yes, admission notification is required for every inpatient admission. The admission notification requirement applies even if a referral or prior authorization is on file. Admission notification is the hospital's responsibility, as outlined in the current Administrative Guide.

Member Billing

Q23. Can members be billed for non-covered services?

A. Yes. In accordance with the terms of your participation agreement, you may bill members for non-covered services under certain circumstances.

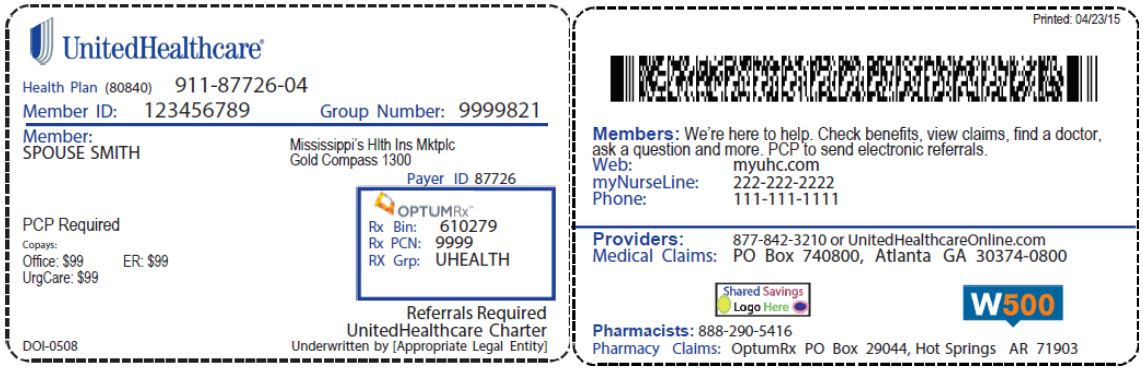
For example, while joint replacements are generally covered benefits, a medical necessity review may determine a particular joint replacement for a member is not covered. If the services you provide are not covered under the member's benefit plan for reason of not being medically necessary, you may bill the member only if they have been informed of the decision of non-coverage prior to the date of the service and have specifically agreed in writing to accept financial responsibility. The written agreement must indicate the member understands UnitedHealthcare has determined the service is non-covered and the member chooses to receive the service and be financially responsible for payment.

Resources

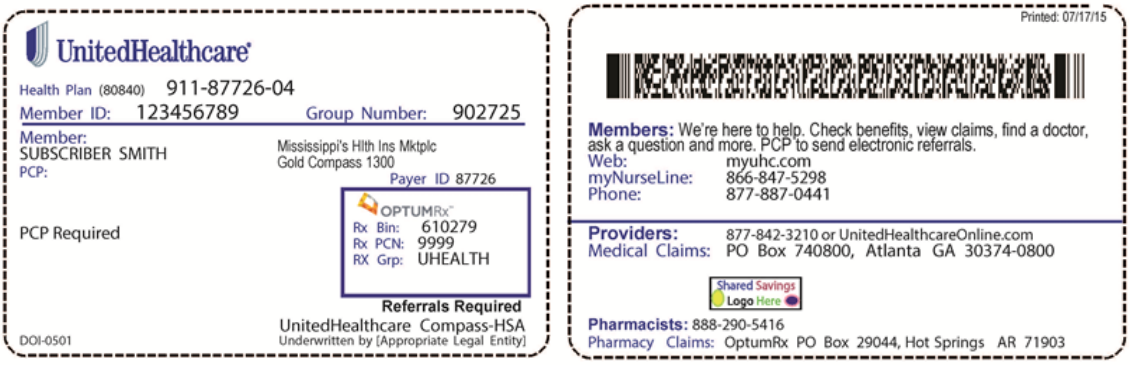
Q24. How will information appear on the member ID cards?

A.

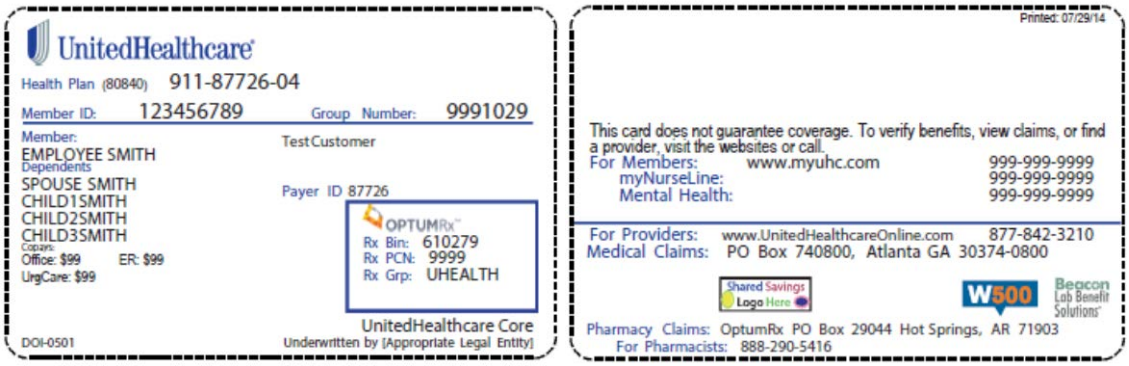
UnitedHealthcare Charter:



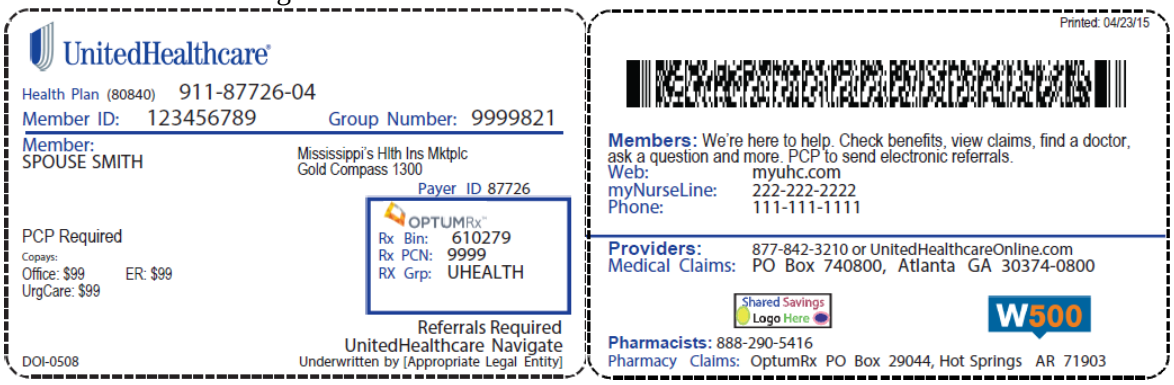
UnitedHealthcare Compass:



UnitedHealthcare Core:



UnitedHealthcare Navigate:



Sample ID cards are for illustration only. Actual cards may vary by benefit plan design and other requirements.

Q25. What if I have questions about these health plans?

A. Please contact Provider Services at 877-842-3210 or go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services.