Oct. 21, 2015

Re: Your Participation with UnitedHealthcare Medicare Advantage Referral-Required Plans

UnitedHealthcare Medicare Advantage referral-required plans will be offered in your county effective Jan. 1, 2016. **These plans are included in your participation agreement with us because you are a UnitedHealthcare Medicare Advantage participating provider.** Following is information to help you coordinate care for your patients who are members of these benefit plans.

**Health Plan Features**
Medicare Advantage referral-required plans emphasize the role of the primary care physician (PCP). Members are required to choose a PCP, who helps coordinate their health care needs and manages referrals to participating specialists. These plans require referrals for specialty care as well as admission notification. Prior authorization and advance notification are also required.

**Preparation Checklist**
- Review online tutorials and other Medicare Advantage referral process information at UnitedHealthcareOnline.com > Tools & Resources > Products & Services > Medicare.
- Share the enclosed quick reference guide and online resources with your staff and discuss any potential changes to your administrative processes.
- Attend a town hall meeting in October and November 2015 to learn more about the Medicare Advantage plans available in your area. We will send you more information about upcoming town hall meetings.
- Sign up for an online webinar training session to become familiar with the referral-required plans in which you participate and understand the referral submission process. Invitations for these webinars will be sent soon.

If you have questions, please contact Provider Services at 877-842-3210. Thank you.
Plan Description

UnitedHealthcare Medicare Advantage referral-required plans emphasize the role of the primary care physician (PCP). Members choose a PCP who oversees their health care needs and manages referrals to participating specialists.

Plan Features

Following are key features of these plans:

<table>
<thead>
<tr>
<th>Key Feature</th>
<th>Required</th>
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<tbody>
<tr>
<td>Requires members to choose a PCP</td>
<td>Yes</td>
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<tr>
<td>Requires referrals for specialty care</td>
<td>Yes</td>
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<tr>
<td>Admission notification protocols apply</td>
<td>Yes</td>
</tr>
<tr>
<td>Prior authorization/advance notification requirements apply</td>
<td>Yes</td>
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</table>

The referral-required plans can be identified by plan name, plan benefit package (PBP) number and referral required language on the front and back of the card.

The sample ID cards are for illustration only. Actual cards may vary.
Frequently Asked Questions

Q1. How do I identify members in a referral-required plan?
A. Referral-required plans can be identified by plan name, PBP number and referral required language on the front and back of the card.

Q2. Can members seek care outside the plan service area in which they live?
A. Yes, depending on the member’s benefit plan, they may have a “passport feature” that allows them to seek health care in another location. Emergency care is covered worldwide with all UnitedHealthcare Medicare Advantage plans.

Q3. How do I know if I am a network care provider for these benefit plans?
A. You are participating unless your participation agreement specifically excludes you from participation in the plans. You will also be listed in the provider directory for each benefit plan. You can confirm your participation status while verifying patient eligibility and benefits, or by viewing the online provider directory at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory.

Q4. How do I search for physicians, facilities or other health care professionals who participate in the network?
A. Please go to UnitedHealthcareOnline.com > Physician Directory > General Physician Directory.
   • Select the member’s plan.
   • Search for a physician by name, specialty and/or condition.
   • Narrow the search by zip code.
When a member searches for a care provider, the only names that appear are physicians who participate in the member’s network.

Q5. **Do members have to select a PCP?**
A. Yes, each member in a referral-required plan must choose a PCP to assist with their health care needs and generate referrals to network specialists. If a member does not choose the PCP during open enrollment, then one will be assigned to the member. The assigned PCP and phone number is listed on the front of the member’s ID card.

Q6. **How often can members change their PCP?**
A. Members may change their PCP every month. If the change is requested on or before the 15th of the month, it will be effective on the first day of the following month. Changes submitted on or after the 16th of the month may not be effective until the first day of the second following month. Please note referrals previously submitted by the member’s PCP will not be affected by the change in PCPs.

Q7. **Who is responsible for generating referrals?**
A. The member’s PCP coordinates the member’s care and submits referrals to network specialists prior to the member seeking care with other network physicians. If care providers do not follow referral requirements, claims will be denied as a result.

Q8. **What services require a referral?**
A. Referrals are required when a member seeks care from a network specialist. Referrals are not required for facilities or ancillary providers, or for the following services:

- Any service provided by a network PCP or a network physician practicing under the same tax ID as the member’s PCP
- Any service from a network obstetrician/gynecologist, chiropractor, podiatrist, optometrist, ophthalmologist, optician or podiatrist
- Allergy shots (95115- 95170, 95199)
- Mental health/substance abuse services with behavioral health clinicians
- Any service from a pathologist or anesthesiologist (excludes office-based or pain management services), any inpatient consulting physicians including hospitalists
- Services rendered in any emergency room, emergency ambulance or a network urgent care center or convenience clinic
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, vision or hearing exams
- Any lab services and radiological testing service (excluding radiation therapy)
- Durable medical equipment (DME), home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies or Medicare Part B drugs
- Services that may be covered by some Medicare Advantage plans but are not covered by Medicare, such as hearing aids, routine eyewear, fitness benefits that may include a gym membership, or outpatient prescription drugs
- Services obtained under the UnitedHealth Passport benefit, which allows for services while traveling

For more information, please refer to the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols & Guides.
Q9. **What if a member requires care not available from a network specialist or facility?**
A. If there are no network specialists or facilities available to provide a specific covered service, the member’s PCP can submit a request for services to be provided by a non-network provider at the in-network benefit level. The member’s PCP may request an exception by calling the number on the back of the member’s ID card.

UnitedHealthcare will review the request and determine whether or not a 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 benefit level. UnitedHealthcare will send written confirmation of the final decision to the requesting physician and the member.

Q10. **How many visits are included with each referral?**
A. The PCP will determine the number of visits necessary for each referral within a specified timeframe. After the initial visits are used or if unused visits expire, the PCP may submit another referral to the network specialist.

Q11. **Can member referrals be viewed online?**
A. Yes. Referrals may be verified at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Referral Submission. You may view a member’s referrals under Referral Status Detail, including information on the network specialist the member is referred to, number of visits authorized and number of visits remaining.

Q12. **Do specialists have to confirm referrals?**
A. Yes. Specialists are expected to confirm a referral is on file prior to seeing the member.

Q13. **What if a member needs to see another specialist or return for additional visits after the referral has expired or all visits have been used?**
A. In both cases, the member’s PCP must be contacted to consider an additional referral.

Q14. **How do PCPs complete specialist referrals?**
A. Referrals must be submitted before the specialist service is performed at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Referral Submission. The referral is effective immediately. Referrals cannot be accepted by phone, fax or paper.

Referrals may be entered on UnitedHealthcareOnline.com with a start date up to five calendar days prior to the date of entry. Comments are not required to process the referral. For more information on how to submit referrals, please see the Referral Submission Quick Reference at UnitedHealthcareOnline.com > Help > Quick Reference > Notification/Prior Authorizations > Referral Submission Quick Reference. Referrals may also be submitted on Link.

Q15. **Does my office staff need specific access to UnitedHealthcareOnline.com to submit or view referrals on file for members?**
A. Yes. If you have assigned your staff as “Pre-Defined Role Type: All Transactions on UnitedHealthcareOnline.com,” 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, please see the Quick Reference Guide at UnitedHealthcareOnline.com > Help > Quick Reference > User ID & Password Management > Roles Function Quick Reference.
Q16. **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, option 2.

Q17. **Do referral-required plans require prior authorization or advance notification?**
   A. Yes. Prior authorization for certain planned services is required so we can determine if the services are covered under the member’s benefits. Prior authorization is approved only for services determined to be medically necessary according to the member’s benefits and applicable policies and guidelines.

   The list of services requiring prior authorization and the process for providing advance notification are the same protocols as described in the Notification Requirement section of the Administrative Guide. It is the physician’s responsibility to follow the advance notification or prior authorization procedures outlined in the Administrative Guide.

Q18. **Is admission notification required?**
   A. Yes. Admission notification is required for every inpatient and applies even if a referral or prior authorization is on file. Admission notification will continue to be the responsibility of the hospital as outlined in the current Administrative Guide.

Q19. **Can members be billed for non-covered services?**
   A. Yes. According to your provider agreement with us, members can be billed for non-covered services. For example, while joint replacements are generally covered benefits, a medical necessity review may determine a particular joint replacement for a member is non-covered. In these cases, members can be held financially responsible for non-covered services only if they have received an Integrated Denial Notice (IDN) informing them of the decision of non-coverage prior to the date of the service, and they 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. Please make sure the member has received an IDN before rendering the non-covered service.

Q20. **What if I have questions about the health plan?**
   A. Please contact Provider Services at 877-842-3210. You can also find information at UnitedHealthcareOnline.com > Tools & Resources > Products & Services > Medicare.