ACCESS PLAN – COVER SHEET

UnitedHealthcare of Colorado
HIOS ID 59036, CON003, Navigate

Required Access Plan Elements

1. Standards for network composition:

   Describe how the issuer establishes standards for the composition of its network to ensure that networks are sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay. Standards must be specific, quantifiable, and measurable based on the anticipated needs of their membership. Common approaches include provider-to-enrollee ratios and time and distance standards. Issuers must also document that their proposed network meets these standards.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented process to establish standards for network composition?	Yes	Pages 4, 9-10
Does the issuer's standard address how the network will be sufficient in number and type of providers, including mental health and substance abuse services?	Yes	Pages 4, 9-10
Is the issuer's standard quantifiable and measurable?	Yes	Pages 4, 9-10
Does the issuer provide documentation or evidence that its proposed network meets its standard?	Yes	Pages 4, 9-10

2. Referral policy:

   Describe the issuer's procedures for making referrals within and outside of its network.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented process for making referrals inside and outside the network?	Yes	Pages 5-6
Does the process allow members to access services outside the network when necessary?	Yes	Pages 5-6

3. Ongoing monitoring:

   Describe the issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of the population enrolled.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented process for monitoring, on an ongoing basis, the sufficiency of the network to meet the needs of its members?	Yes	Page 6
Does the issuer include a both quantifiable and measurable approach to monitoring ongoing sufficiency of its network?	Yes	Page 6

4. Needs of special populations:

   Describe the issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented process to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities?	Yes	Pages 6-7
Does the issuer's process identify the potential needs of special populations?	Yes	Pages 6-7
Does the issuer's response describe how its process supports access and accessibility of services for special populations?	Yes	Pages 6-7

5. Health needs assessment:

   Describe the issuer's methods for assessing the needs of covered persons and their satisfaction with services.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented method for assessing the needs of covered persons?	Yes	Page 7
Does the proposed method include a review of quantitative information?	Yes	Page 7
Does the proposed method assess needs on an ongoing basis?	Yes	Page 7
Does the proposed method assess the needs of diverse populations?	Yes	Page 7

6. Communication with members:

   Describe the issuer's method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care?	Yes	Pages 7-8
Does the method address the process for choosing or changing providers and access to emergency or specialty services?	Yes	Pages 7-8
Does the process describe how it supports member access to care?	Yes	Pages 7-8

7. Coordination activities:

   Describe the issuer's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented process for ensuring coordination and continuity of care?	Yes	Page 8
Does the proposed process address specialty care referrals; ancillary services, including social services and community resources; and discharge planning?	Yes	Page 8
Does the response describe how the process supports member access to care?	Yes	Page 8

8. Continuity of care:

   Describe the issuer's proposed plan for providing continuity of care in the event of contract termination between the health issuer and any of its participating providers or in the event of the issuer's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, issuer's insolvency, or other cessation of operations and how they will be transferred to other providers in a timely manner.

Evaluation criteria	Included in Access Plan	Page number for supporting documentation
Does the issuer have a documented plan for ensuring continuity of care?	Yes	Page 8
Does the issuer have a "hold harmless" provision in its provider contracts, prohibiting contracting providers from balance-billing enrollees in the event of the issuer's insolvency or other inability to continue operations?	Yes	Page 8

Access Plan for UnitedHealthcare of Colorado
HIOS ID 59036, CON003, Navigate

Standards for Network Composition

UnitedHealthcare has specific, quantifiable standards for numeric (provider to member ratios) and geographic (distance) availability of participating providers and practitioners. The network composition is measured against these standards at least annually to ensure the network is sufficient in number and type of practitioner to ensure services are accessible without unreasonable delay. An analysis of the network is also conducted as to how well the network meets member needs and cultural preferences. Standards extracted from this policy are noted in Table 1 and 3 under the column labeled "Standards".

We currently are contracted with 37 percent of the Essential Community Providers (ECPs) in the state-approved service area for this UnitedHealthcare off exchange product. This percentage exceeds the Minimum Expectation for ECP contracting as noted in the CMS Letter to Issuers released on February 29, 2016. We believe that our current complement of network providers is able to support the provision of health care services for membership in the HPSA or low income areas of the state based upon our extensive network that is built to support UHIC's commercial products in the statewide service area for Colorado. We will continue to monitor the adequacy and availability of our current complement of network providers and will undertake any supplemental contracting with ECPs or other provider types that is necessary to ensure continued appropriate access.

Behavioral health services are managed by our sister company, OptumHealth Behavioral (formerly known as United Behavioral Health or UBH). OHB is accredited as a Managed Behavioral Health Organization (MBHO) by the National Committee for Quality Assurance (NCQA) and as part of its annual Quality Improvement and Utilization Management Program conducts an assessment of its provider network to ensure it is sufficient in number and type of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our membership. Standards extracted from this policy are noted in Table 2 and 4 under the column labeled "Standards".

Medical Services Results and Analysis: The results of the most recent analysis are presented in Tables 1 and 3 of this document. Overall, the analysis demonstrates the network adequacy goals across Colorado for numeric availability were met. Network adequacy goals for geographic availability for primary care and high volume medical specialties were met with the exception of Dermatology in Otero County. At this time there are no available providers in Otero county with the specialty of dermatology to contract with and include in the network. If at such time providers become available United Healthcare would be committed to use best efforts in contracting with those providers to provide dermatology services to our members. There are Dermatology providers in the neighboring county of Pueblo, where members could obtain services. Additionally, many primary care providers can provide basic dermatology services but if more extensive services are required to treat a member, those members will need to be referred to the closest county/community to a contracted dermatologist.

Behavioral Health Results and Analysis: The results of the most recent analysis are presented in Tables 2 and 4 of this document. Overall, our analysis demonstrates the network adequacy goals across Colorado for both numeric availability and geographic availability of behavioral health practitioners were met.

Referral Policy

UnitedHealthcare is offering our Navigate product for this off exchange offering. Navigate is a single-tier benefit, network-only product. Members must have a referral from their primary physician to receive network benefits for services from any network physician who is not practicing under the same tax identification number (TIN) as their primary physician. If members seek care from a network physician outside of their primary care physician's TIN without a referral, there is no benefit for that physician's services and related facility services, and the member is responsible for the billed amount (subject to the services that do not require a referral as listed in this section).

Members are required to select a primary physician. The primary physician performs primary care services and generates referrals to network specialists. The Navigate product name and member's primary care physician are indicated on the Navigate member's health care identification card. Reference to referrals being required is on the back of the identification card.

The member's primary care physician coordinates the individual's care and generates referrals to network specialists on the Referral Submission screen on UnitedHealthcareOnline.com prior to the individual seeking care with any network physician not practicing under the same TIN as the primary physician. Retroactive referrals and referrals to non-network physicians are not accepted. Except in cases of fraud or abuse, once a referral is approved by UnitedHealthcare, the referral cannot be retrospectively denied or changed.

If a network specialist to whom the member has been referred identifies the need for a member to see another specialist, the individual's primary care physician must be contacted for the primary physician's consideration of an additional referral. Only the member's primary care physician or a physician practicing under the same TIN can write a referral to a network specialist. A specialist cannot enter a referral.

Referrals are not required for the following services provided by a network physician:

- Services from a network Obstetrician/Gynecologist, including any type of OB-GYN (e.g., perinatologist).
- Services from a pathologist, radiologist or anesthesia physician.
- Services from a physician practicing under the same TIN as the primary physician.
- A routine refractive eye exam from a network provider.
- Mental health/substance use disorder services with network behavioral health clinicians.
- Services rendered in any emergency room, emergency ambulance, network urgent care center, or network convenience clinic.
- Physician services for emergency/unscheduled admissions.
- Services from inpatient consulting physicians.
- Any other services for which applicable law does not allow us to impose a referral requirement.

Referrals are not required for any non-physician type of network services which include but are not limited to:

- Outpatient lab, x-ray, or diagnostics.
- Physical therapy, DME, home health, prosthetic devices, hearing aids.
- Rehab services with the exception of manipulative treatment and vision therapy (i.e., physician services).

Out-of-Network Requests and Continuing Care: UnitedHealthcare also has a documented process for providing services, when necessary, outside of the network. Upon receipt of a provider or member's coverage request to begin or continue treatment with an out-of-network provider, the procedures under the utilization management program provide for administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the individual's benefit plan coverage of services is exhausted while the individual still needs care, the organization will offer services, as required, to educate the consumer about alternatives for continuing care and how to obtain care.

In the event of a physician termination, affected member will be notified at least 30 calendar days prior to the effective date of termination, or as required under applicable laws. Member notification is performed through the Provider Termination System (PTS) Process. The PTS process generates legally approved member notification letters for both potential terminations, and hospital network. The process is outlined in the policy titled "Provider Additions, Potential Terminations, and Actual Terminations".

Procedures covering both situations are documented in the policy titled "Out of Network Requests and Continuing Care". The purpose of the process is to provide timely and consistent determinations and notices for all out of network coverage requests and to ensure members have needed information regarding alternatives for continuing care. Examples of Out of Network Coverage Requests include the following:

- **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.
- **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly member who is receiving ongoing care a transition period before they are required to transfer from an out-of-network provider to an in-network provider and to receive network benefits under the terms of the employer health benefits or government program contract for the transition period.
- **Continuity of Care (CoC):** A request for CoC is based on a benefit which allows a member to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The member is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider under the terms of the employer health benefits or government program contract.

On-Going Monitoring:

In accordance with UnitedHealthcare's Practitioner Availability policy regarding availability and accessibility of providers, we conduct a thorough assessment annually to ensure that the network is sufficient in numbers and types of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our membership.

Needs of Special Populations:

As a company that serves more than 75 million people across our lines of business, UnitedHealth Group has a distinct incentive to ensure that our products and services are accessible to everyone. We believe that health disparities exist in large part because individuals are seen merely as part of a population and not people with unique needs. We have adopted a philosophy that **better information** leads to **better results** and, ultimately, **better health.** That value also extends to our multicultural initiatives. We address health disparities on several fronts: education, accessibility, usability, data collection and health or wellness programming. We also participate in the health care disparities discussion/agenda at both the national and community levels.

Evaluation of members' cultural, ethnic, racial and linguistic needs may be measured using the following data sources:

- Member satisfaction survey data**
- U.S. Census Data
- Network Database (NDB)
- Enrollment data

- Focus groups
- Other sources as required or needed

We use this data in our annual Practitioner Availability report to determine if we have sufficient practitioners in our network to meet the cultural and linguistic needs of our members. Based on the outcome of this assessment, adjustments may be made to the health plan networks to improve cultural availability.

To address the needs of members with literacy issues, UnitedHealthcare Customer Care can provide assistance in how to access care by providing benefit information and information on in network providers. To further aid members with special needs, our provider directories (available online or via phone) provide information on providers including gender and language capabilities.

In collaboration with our sister company Optum Health, each year we conduct a comprehensive assessment to evaluate the characteristics and needs of our member populations and subpopulations relevant to complex case management programs. The results of this assessment are utilized in developing or revising complex case management programs and services, and in identifying and evaluating measures of effectiveness. The characteristics included in this assessment include:

- Age
- Gender
- Clinical diagnosis (medical and/or behavioral
- Special needs: hearing impaired and/or vision impaired
- Translation services
- Member satisfaction data

Health Needs Assessment:

Members are encouraged to access a thorough health risk assessment that is available either online, by mail, or completed over the phone with the assistance of our Customer Care team. Our predictive modeling software is applied to continually monitor customer needs by incorporating claim, pharmacy and utilization management data to identify customers who may benefit from care management services.

Results from the health risk assessment and output of predictive modeling software are used to assess needs of members. Feedback from members is also solicited on an ongoing basis. At least annually, the overall assessment of members and their feedback is incorporated into an evaluation of program's effectiveness.

Communication with Members:

It is the policy of UnitedHealthcare to ensure that members have access to information regarding key topics about their benefits and plan design including but not limited to:

- Member rights and responsibilities,
- Accessing Customer Care,
- Voicing complaints and grievances,
- Choosing and changing primary care physicians,
- Accessing routine, specialty and emergency care, and
- Understanding benefit coverage exclusions, restrictions and notifications.

Procedures for communicating with members are outlined in the policy titled "Member Communication". Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide and

the annual Rights and Resource Disclosure Booklet. Members also have access to myuhc.com, a website with resources for accessing personal health records, finding physicians, and encouraging healthy behaviors.

Coordination Activities:

Members are required to select a primary care physician. The primary care physician performs primary care services, coordinates care and generates referrals to network specialists. In addition, UnitedHealthcare offers multiple care coordination programs. Many of the programs offered are focused on delivering skilled resources to assist members with improved self-management by assuring that they understand the provider's care plan, the medication instructions, and have support for the right lifestyle changes. In order to access these programs, members may be referred by their primary care physician or contact their UnitedHealthcare representative through the phone number listed on the back of their health care ID card. Examples of care coordination programs include the following:

Transitional Case Management: Transitional Case Management (TCM) is the collaborative process of evaluating and coordinating post-hospitalization needs for members identified as being at risk of re-hospitalization or as frequent users of high-cost services. The goal of TCM is to facilitate access to services so that the member receives timely provider and home health services, medications, medical equipment, oxygen, therapies and other support as required.

General Condition Management: General Condition Management serves members with chronic conditions, those in need of longer-term support, or those who have unmet access, care plan, psycho-social, or knowledge needs.

Continuity of Care:

UnitedHealthcare's provider participation agreement includes language that requires continued access after termination to ensure continuity of care for specific medical conditions. Procedures are in place to ensure that members are notified when any of their active providers terminate participation agreements and that when clinically appropriate members are allowed continued access to terminated providers at an in-network benefit level.

Provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations. The language states: "Medical Group will not bill or collect payment from the Customer or seek to impose a lien, for the difference between the amount paid under this Agreement and Medical Group's billed charge or Customary Charge, for any amounts denied or not paid under this Agreement due to: i) Medial Group's failure to comply with the Protocols, ii) Medical Group's failure to file a timely claim, iii) Payer's payment policies, iv) inaccurate or incorrect claim processing, or v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable laws to assure that its Customers not be billed in such circumstances..."(Section 7.8).

Standards and Results:

The plan ensures services are geographically accessible and are distributed so that no member residing in the service area must have an unreasonable distance to obtain covered services provided by Primary Care Physicians (PCP) or high volume specialists (HVS). Exception requests are addressed in Utilization Management policies.

Table 1 - Numeric Availability – Medical Services

Physician Specialty	Standards	Analysis
PCP All Types Family Practice General Practice Internal Medicine Gerontology Pediatrics OB/GYN	1:1,000	Met
Allergy / Immunology	1:10,000	Met
Cardiology	1:2,000	Met
Dermatology	1:8,000	Met
Obstetrics / Gynecology	1:2,000	Met
Oncology / Hematology	1:4,000	Met
Ophthalmology	1:2,000	Met
Orthopedics	1:2,000	Met

Table 2 - Numeric Availability – Behavioral Health and Substance Abuse Services

Provider Type	Standards	Analysis
Child & Adolescent (MD, PhD, MA)	1.0: 1,000	Met
Psychiatrist & RN with Prescriptive Privileges	0.5: 1,000	Met
Doctoral, Master's Level	0.5: 1,000	Met

Table 3 - Geographic Availability – Medical Services

Physician Specialty	Standards					Goal	Results					Analysis
	Large Metro	Metro	Micro	Rural	CEAC		Large Metro	Metro	Micro	Rural	CEAC	
Primary Care	1:5 miles	1:10 miles	1:20 miles	1:30 miles	1:60 miles	90%	99%	99%	99%	100%	100%	Met
Cardiology	1:10 miles	1:20 miles	1:35 miles	1:60 miles	1:85 miles	90%	99%	99%	100%	100%	100%	Met
Dermatology	1:10 miles	1:30 miles	1:45 miles	1:60 miles	1:100 miles	90%	99%	99%	100%	79%	100%	Not Met
Obstetrics / Gynecology	1:15 miles	1:30 miles	1:60 miles	1:75 miles	1:110 miles	90%	100%	99%	100%	100%	100%	Met
Oncology / Hematology	1:10 miles	1:30 miles	1:45 miles	1:60 miles	1:100 miles	90%	99%	99%	100%	99%	100%	Met
Ophthalmology	1:10 miles	1:20 miles	1:35 miles	1:60 miles	1:85 miles	90%	99%	99%	100%	100%	100%	Met
Orthopedics	1:10 miles	1:20 miles	1:35 miles	1:60 miles	1:85 miles	90%	99%	99%	100%	100%	100%	Met

Note: CEAC – Counties with Extreme Access Considerations

Table 4 - Geographic Availability – Behavioral Health and Substance Abuse Services

Provider Type	Standards			Goal	Results			Analysis
	Urban	Suburban	Rural		Urban	Suburban	Rural	
Child & Adolescent (MD, PhD, MA)	1:10 miles	1:20 miles	1:45 miles	90%	100%	100%	99%	Met
Psychiatrist & RN with Prescriptive Privileges	1:10 miles	1:20 miles	1:45 miles	90%	99%	100%	99%	Met
Doctoral, Master's Level	1:10 miles	1:20 miles	1:30 miles	90%	100%	100%	99%	Met