UHC FAQs 2019-2020

For internal use only

Eligibility

1. What is the age limit for dependent coverage under the plan?
UHC complies with Health Care Reform and covers dependent children to the age of 26, with no student requirement. State specific mandates for dependent children age 26 and over apply on FL-situsedplans, and NY-situsedplans.

All Florida-situsedplans: To be eligible for the extended dependent coverage, the parent(s) must be actively covered under a **Florida issued group health contract** and the eligible dependents must be the insured's child (by blood or by law) and must meet the following criteria:

- under age 30;
- not married;
- without his or her own dependents;
- a resident of Florida, **or Part-time or Full-time student**;
- not a named subscriber, insured, or enrollee under another plan; and
- not eligible for Medicare.

All New York- situsedplans: **NY29/Young Adult coverage will be included for overage dependents who meet the following criteria:

- under age 30;
- not married;
- not insured or eligible for coverage, as an employee or member, under a self-funded or fully-insured, employer sponsored plan (including HMO); and
- live, work or reside in New York or the service area of the carrier.

<u>Important Notes</u> on NY-situsplan:

- Overage dependents are not required to enroll and pay a separate premium. Their coverage will continue under the parent's plan as a dependent. UHC will not require the child to move under their own policy.
- Overage dependents does not have to live with a parent, be financially dependent on a parent, or be a student.
- Overage dependents will age off their parent's plan at the end of the year in which they reach age 30. They will then be eligible for 36 months of COBRA coverage.
- If an overage age dependent no longer meets the criteria (e.g. the dependent gets married), then the parent should remove the dependent as of the end of the month that the dependent no longer qualifies. The dependent's termination date will be the end of the month that ADP is notified that the dependent no longer meets the criteria. The dependent will then be eligible for 36 months of COBRA.

2. How does the plan confirm overage student eligibility on FL-sitused plan?
UHC sends out the student verification letter at the time of the first claim and then at the semester mark; typically January and September. Until carrier receives the student status letter back from the subscriber all claims for that student are on hold and will not be paid; this sometimes prompts phone calls as they also receive EOBs explaining that *"we are requesting additional information from the member and the claim cannot be processed at this time".* Carrier will not update per phone, we must something with the subscriber's signature. Proactive calling campaigns have been known to occur.

3. When a dependent is no longer eligible due to age, when will the coverage actually end (i.e., month of birth date or at the end of the calendar year)?
For ADP TotalSource – The coverage ends at the end of the month of the date the dependent is no longer eligible to be an enrolled dependent. *

*Florida-sitused and NY-sitused plans: at the end of the calendar year.

4. What determines a member's eligibility for coverage in terms of plan service area (i.e. live/work rule)?
EE must live or physically work in the service area for applicable plan. ADP Site-matching is to be done to confirm network availability.

5. Is a dependent child that is away at school – or lives with a parent that is not in the service area – eligible for enrollment?
Dependent children away at school or residing with a parent not located in the service area are eligible for coverage, depending on plan type.

Dependents enrolled in Choice Plus plans would have network benefits available if the dependents utilize a UHC contracted provider and there is access to the Choice Plus network. Otherwise, out-of-network benefits are available.

PPO Plans have a national network that is accessible to subscribers and their dependents.

Dependents enrolled in HMO plans would only be covered for emergencies if not in the HMO service area.

Dependents enrolled in Choice plans would have network benefits available if the dependents utilize a UHC contracted provider and do not reside in one of the eleven restricted states: AK, AL, AR, AZ, HI, KS, LA, MN, NC, NM, or OK. If the dependents reside where there is no Choice network, they will only be covered for emergencies.

Navigate plans:
Navigate HMO: Navigate HMO members can only access emergency, urgent care, or convenience care clinics while traveling out of state. These are gatekeeper plans and all non-emergency / non-urgent care must be coordinated by the PCP.
Question: Can a student who is living away from home select a primary physician in the state where they are attending school (if that state happens to be different than the state of the subscriber's residence)?

Answer: No. Students must select a primary physician in the state where the subscriber resides or in a contiguous market to that state. Hence, Navigate members may select a PCP within their own market (based on home address) or within a market contiguous to that home address.
Question: What if the student enrolled in Navigate needs medical care while away at school? Answer: If a student has a medical emergency, they will be covered for emergency care received in any hospital emergency room facility. If a student requires non-emergency medical attention, they also have the option to seek care through any Navigate network urgent care or convenience care clinic (without a referral from their PCP). However, the member must get a referral from their PCP to see a specialist or other network provider in the network service area where they are attending school.
Note re Rx script on Navigate Plan: As long as the medication is covered under the member's plan and a network pharmacy is used UHC will not deny the claim for medication. It does not matter if the prescription was written by the assigned PCP or a specialist, with or without a referral.

6. Are dependents of an eligible dependent (employee's grandchild) covered by the plan? If yes, for how long?
Yes; but only if the subscriber or the subscriber's spouse has been awarded legal guardianship of the grandchild (see exceptions below for FL & TX situsedplans). The definition of dependent can be found in the Certificate of Coverage.

Florida-situsedplan: Yes, the dependent of a dependent can be covered for up to 18 months.

Texas-situsedplan: A grandchild of the subscriber who, at the time of initial enrollment, is financially dependent on the subscriber for federal income tax purposes, up to the age of 25.

7. Are Medicare-Age employees or Medicare-age dependents of an active employee covered under the plan?
Yes.

8. What is UHC's policy regarding dependent social security number?
UHC requires SSNs for new enrollees and other members for whom the company does not have a SSN on file per IRS regulations. Carrier expects the employer groups to pass this information to ADP.

Plan Provisions

1. Will the plan honor a prior carrier's deductible and out of pocket satisfied in the calendar year?
Yes; for new groups or at Open Enrollment. New hires are not eligible for credits. Note: Prior group plan must be for the same company coming to TS. ADP WSE must be the subscriber on prior group plan for additional family members to receive credit. If ADP WSE is only a member on prior group plan, but enrolls for TS benefits as a subscriber when onboarding (i.e. also works for the same company but was previously a dependent on the plan), WSE will **not be eligible** for a credit. If WSE was a subscriber on prior group plan and will enroll as Dependent on TS plan, WSE will **not be eligible** for a credit.

New Business client to UHC's book:

Open-market UHC plan to ADP UHC plan: The member will need to complete a Claim History Coversheet and submit along with the prior carrier's Explanation of Benefits (EOB) to UHC for processing (updated copy of Claim History Coversheet is available to TS associate in ADP SharePoint). Each UHC member will need to retrieve their EOB on myuhc.com (UHC is not able to do this for the member or at ADP's request).

Non-UHC carrier to ADP UHC plan: The member will need to complete a Claim History Coversheet and submit along with the prior carrier's Explanation of Benefits (EOB) to UHC for processing (updated copy of Claim History Coversheet is available to TS associate in ADP SharePoint). This is the Standard method for prior non-UHC groups; see below for Exception alternative.

Exception to Standard process above for Non-UHC carrier to ADP UHC plan:
UHC will also accept a group report from the prior non-UHC carrier when a group is newly added to UHC. Client would initiate the request with their prior carrier, unless the prior carrier is already partnering with TS (NOTE: not all TS carriers can produce this report).

If the prior carrier is able to produce a group report (not every carrier can do this), preferably in excel format, with data only from January 1st of current calendar year to start date on UHC, the report must be sent from prior carrier *directly* to: ADPdeductiblecredit@uhc.com.

The cover email from prior carrier to UHC must contain the following:

a) Client's term date with prior carrier
b) Client's start date with UHC at ADP

ADP IC or Benefits Services Specialist must also send an email to adp_service@uhc.com to alert the team to expect the Group report from prior carrier. This email must include:

1) Company name and pay code
2) Benefit Start date under TS
3) Policy number(s) for the ADP UHC plans

ADPTS June Open Enrollment:
Members from an ADP-UHC plan moving to another ADP-UHC plan – Credits are typically automatic within a 2 week rollout period. ***Credits that are not automatic are for members that have moved from Policy A to Policy B and back to Policy A. These credits are a manual process and UHC will need to be contacted for help. Typically this is known when the member contacts ADP to inquire why their credit has not been transferred.

2. If the plan will honor a prior deductible and out of pocket, what is included in the deductible and out of pocket credit?
Members will receive credits of the individual amounts met on the prior plan up to the ADP plan maximums for the calendar year only. Overages will not get applied to other family members or accumulators. Credits will be applied for both in and out of network deductible and out of pocket. Coinsurance, Copayments and Deductibles apply toward the out of pocket maximum. There are no restrictions on transfer of credits between plan types, example: prior HMO plan can receive credit when moving to HDHP, etc.

3. Will the plan honor a prior deductible and out of pocket from an individual plan vs. a group plan (for example, individual coverage through a marketplace plan)?
No; credits are applied for new groups (not new hires) or at Open Enrollment, when the prior plan is a group plan only.

4. Does the plan have a 4th quarter deductible carryover provision?
No. *GA-situsedplans, however, do have a 4th quarter deductible carryover provision due to state mandate. It does not however, apply to high deductible health plans (HDHP).

5. If applicable, are the deductibles and Out-of-Pocket Maximums for the Network & Out-of-Network interchangeable?
Amounts applied toward the Network deductible **do not** apply toward the Out-of-Network deductible, and vice versa.

6. What method is used to calculate the out-of-network expenses (i.e. UCR, eligible expenses, etc.)?
Reimbursement is based on Medicare (CMS) resource-based relative value scale (RBRVS) for physicians & other health care professionals. Medicare (now known as CMS – Centers for Medicare and Medicaid Services) rates are independently derived and regulated – using consistent geographic, demographic and other criteria to determine the true cost base of health care services in an area. Medicare payment standards are understood and accepted by physicians and other health care professionals nationally. Indemnity or PPO plans are excluded.

7. Explain emergency room coverage in a Non-Par Facility, and how an admission associated with the emergency will be covered. How will charges for hospital, physicians, and ancillaries be paid?
The Patient Protection and Affordability Care Act (PPACA) includes a formula for reimbursement of emergency health services delivered by non-participating professionals and facilities. Typically, this formula results in a rate that is the median network reimbursement rate for the emergency service provided. Members may be balance-billed the difference between the provider's billed amount and the reimbursement schedule; payment of this non-covered amount

by members will not apply to their out-of-pocket maximum. The emergency room copayment is waived if the patient is admitted within 24 hours of the initial emergency room treatment.

8. Explain how the plan would pay non-par physician or ancillary charges in an emergency or non-emergency situation at a par hospital (i.e. the plan contracts with the hospital, but not with the hospitals anesthesiologist, x-ray, lab, etc.)
See item 5 for emergency situation. For non-emergency, when using out-of-network doctors, health care professionals or facilities, costs may be higher and members may be balance-billed. Any balance-bill paid for services from an out-of-network provider does not apply to the out-of-pocket limit. Please refer to the plan COC for more details.

9. What is the process for a new member undergoing treatment with a non-par provider to receive uninterrupted care as they transition to the plan? Are there any special provisions for pregnancy?
If a member is currently undergoing a course of treatment with a non-par provider as they transition to the plan, the member must contact Member Services at the toll-free number on the back of their United HealthCare identification card as soon as possible. If guidelines are met, the member may apply for a transition of care, where UHC will consider allowing the member to utilize a Non-Network provider but may process the expenses at a Network benefit level while the member is transitioned to a UHC Network Provider.
In most instances, a pregnant member may remain with a Non-Network Provider if she is in her third trimester of pregnancy.

10. Is there a Continuity of Care policy for members impacted by a participating provider termination?
Yes. Existing members may receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians. Member must complete a Continuation of Care Form.

11. What is the penalty for not pre-certifying Benefits requiring pre-certification?
A member's failure to obtain pre-authorization could result in denial of coverage and /or reduction in benefit. The member is responsible for ensuring that the appropriate pre-authorization for services and supplies has been obtained.

12. How would a member access a Mental Health Provider? Is the provider listing published or do they call a separate number?
The member should call the phone number for Mental Health that is located on the back of their identification card. A mental health advocate will assist the member in coordinating their care. Information can also be found on www.unitedbehavioralhealth.com. Members can also use www.myuhc.com or www.liveandworkwell.com directly.

13. Explain the Prescription Drug Program benefit.
UnitedHealthcare plans include a prescription drug benefit that features a 3 tier copayment structure. They offer more flexibility when making decisions about prescription drug purchases. Copayments will depend on the type of drug selected. UnitedHealthcare's preferred drug list predominantly includes the most commonly prescribed drugs. A preferred drug list is provided to members when ID cards are issued. Filling prescriptions for more than a one-month supply is available via mail-order service.

***Note:** PA NAV EPO Plans, in the TS 2019-2020 portfolio, offer a 4 Tier Essential PDL copayment/coinsurance structure.

14. If applicable, please explain the mail-order benefit and how to obtain the materials needed for ordering.
UnitedHealthcare utilizes Optum Rx's Home Delivery Pharmacy mail-order services for maintenance drugs. Copays are, on average, 2.5 times the retail level for up to a 90 day supply. Ordering can be done via the phone, website, or regular mail. Ordering materials and instructions are provided to each member when ID cards are issued.

15. Is there a Specific Lab that UHC contracts with?
UnitedHealthcare is contracted with Quest and LabCorp as participating providers of laboratory services.

16. Is there a pre-existing condition clause on any of the plans?
No. UnitedHealthcare removed all pre-existing conditions effective January 1, 2014, due to ACA.

17. What should a member do if they disagree with a decision that has been made by the plan?
If Member Services has not been able to resolve the member's issue to the member's satisfaction, the member has the right to file an appeal with the plan. Details on how to do so can be found in the certificate of coverage or member may request through member services a copy of "Your Right to Appeal Packet" from:

UnitedHealthcare – Customer Appeals
P.O. Box 30573
Salt Lake City, UT 84130