NETWORK ACCESS PLAN

1. INTRODUCTION

Name of Carrier	UnitedHealthcare Insurance Company/HIOS 67879
Name of Network/Network ID	**Choice Plus** / CON001 Binder Filing # UHLC-CO24-125116807
Type of Network/General Description	The **Choice Plus** plan gives you the freedom to use any doctor or hospital in our national network. However, you must seek care from UnitedHealthcare Choice network providers to receive benefits. You do not need to choose a primary care physician and you do not need a referral to see a specialist. Emergency care is covered at the network level of benefits for you and your covered dependents, anywhere in the world.
Specific Geographic area(s) covered by network	Statewide
Website	https://www.uhc.com/legal/required-state-notices/colorado
Contact Information	Contact information can be found on member ID Card

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESSES

Evaluation Criteria	Response
A. Summary of the carrier's network adequacy standards measured and results of measurements. This is a **written summary** of the number of providers and facilities within a reasonable distance as reported on the Enrollment Document. If any network adequacy standards are not met, this section must identify the provider(s)/facility(ies) that are not adequate. This information will also be included on the Network Adequacy Cover Sheet. The inclusion of measurement tables or specific data is not appropriate.	Our current ratios for the network of providers serving our projected membership has been reviewed and determined to be adequate in each county or within a reasonable driving distance as defined by county designation time/distance specifications. Our analysis reveals that we have **111,105 projected members** in the State of Colorado. To serve these members we have: • 14,525 PCP's • 19,634 Specialists • 7,350 OB/GYN • 12,838 Pediatricians • 25,004 BH/MH • 33,548 SUD Providers • 876 Pharmacies • 86 Hospitals • 86 Emergency Facilities • 156 Urgent Care Facilities • 296 BH/MH • 296 SUD Facilities
B. The carrier's documented, quantifiable, and measurable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of populations enrolled in managed care plans on an ongoing basis. This section requires a description of how telehealth is used (or not used) to meet healthcare needs and network adequacy standards.	UnitedHealthcare has specific, quantifiable standards for numeric (provider to member ratios) and geographic (distance) availability of participating providers and 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. **Telehealth** Telemedicine and Telehealth services, which are services where the physician or other healthcare professional and the patient are not at the same site, are a covered expense. This policy applies to all products and all network and non-network physicians and other qualified health care professionals. Examples of such services are those that are delivered over the phone, via the Internet or using other communication devices. Telehealth Services Coverage is provided for "Telehealth" services the same as other Covered Health Care Services. UnitedHealthcare does not currently use telemedicine services to fulfill the provider network access standards.

C. The factors the carrier uses to build its provider network, including a description of the network and the criteria used to select and/or tier providers.	UnitedHealthcare networks consist of a variety of primary care and behavioral professional, specialists, hospitals, and other facilities. To help provide members with reasonable access to providers who meet their needs, including the number of providers and the types of services offered within a geographic area. Additionally, assessments of how well the network meets members' cultural needs and preferences, including any special healthcare needs. Outreaches to providers are made, as needed, in order to recruit them to participate in UnitedHealthcare's networks. UnitedHealthcare also accepts requests from employers, members, and provider to accommodate needs and preferences. The Choice Plus plan gives you the freedom to use any doctor or hospital in our national network. However, you must seek care from UnitedHealthcare Choice network providers to receive benefits. You do not need to choose a primary care physician and you do not need a referral to see a specialist. Emergency care is covered at the network level of benefits for you and your covered dependents, anywhere in the world. **Identification of High-Volume Specialty Care Practitioners** Top HVS are identified at least annually. For some products more frequent identification of HVS is conducted to meet state, federal and/or other regulatory requirements. Due to differences in data sources and regulatory requirements, methods to identify high volume specialists vary by product type. Commercial/Marketplace Health Plans Identification of HVS is based on visits per 1000 members' data. These data are used to identify the top three high volume specialties. If OB/GYN's are not identified in the top three, then they are added as a fourth specialty. **Identification of High Impact Specialty Care Practitioners** Top HIS are identified, at least annually. Due to differences in data sources and regulatory requirements, methods to identify HIS vary by product type. HVS practitioners may also be designated as HIS when appropriate. **High Volume Specialty (HVS) Care Practitioners**: A type of specialist who treats a significant portion of an organization's membership. **High Impact Specialist(s) (HIS)** A type of specialist who treats specific conditions that have serious consequences for the member and require significant resources. These processes are consistent across commercial products; Choice, Choice Plus and Options Networks.
D. The carrier's quality assurance standards, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care in a network. The inclusion of a corporate quality assurance manual is not appropriate, but a summary and reference to such a manual should be included.	Annually, UnitedHealthcare completes an assessment of Network Adequacy in order to identify areas for improved member access to services. Included in the Network Adequacy assessment are evaluation of Availability (geographic, numeric, cultural and linguistic availability of practitioners), Accessibility (access to appointments based on Consumer Assessment of Healthcare Providers and Systems (CAHPS®1) Health Plan Survey data, other member surveys/data or other member experience data for routine, urgent and after hours care and access to high volume and high impact specialty care. An assessment of complaints and appeals related to access to care is integrated into the analysis. Requests for out-of-network utilization of services are included in the analysis. As a result of this Annual Assessment, High Priority Opportunities are identified and an Intervention plan of action is implemented with an effectiveness report of said intervention being part of the next Annual Assessment.
E. The carrier's description of corrective action processes that will be used to remedy networks found to be inadequate. This plan should include possible remedies, proposed timeframes and schedules for implementation, and proposed notification and communications with the Division, providers, and policyholders.	UnitedHealthcare maintains standards for the numeric and geographic availability of participating practitioners and providers, based on the Colorado Insurance Regulation 4-2-53. UnitedHealthcare analyzes the networks against these established standards monthly. At least biennially, UnitedHealthcare conducts an assessment of how well the network meets members' cultural needs and preferences. Interventions related to both analyses are identified and implemented to improve availability when needed. Assessments are conducted in accordance with state, federal and regulatory requirements.
F. If a network is found to be inadequate, the carrier will explain/describe specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification & communications with the Division, providers, and policyholders. A summary of these corrective actions will be reported on the Carrier Network Adequacy Summary and Attestation Form.	Based on UnitedHealthcare's 2022 provider and facility data extract for the Network Adequacy review, UnitedHealthcare identified provider services that did not meet Network Adequacy. The specific category and in each county in which the network is found to be inadequate is listed in Attachment D under the "Network Adequacy Summary and Attestation Form" section under "Supporting Documentation" section in SERFF. Actions: • UnitedHealthcare is committed to continued research for additional providers entering the market for viable recruitment candidates. If additional providers are identified locally and determined to be viable recruitment candidates, UnitedHealthcare will outreach to those providers to determine their interest in participation. Additionally, as part of our policy, we will negotiate rates for treatment with any available out-of-network provider for members without access on a case by 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. • UnitedHealthcare's free Health4Me mobile app provides members the ability to easily locate nearby health care providers, convenience care, urgent care, and emergency care facilities. • Continue specialty physician access in 2022

	• Continue expansion and member education of Telehealth/Virtual care. • Continue to work with individual offices and urgent care centers to extend open hours and weekend coverage.

G. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network level of benefit, from a non-participating provider should the carrier's network prove to be inadequate.	Members or their providers can request access to an out-of-network provider at in-network rates if an in-network provider is not available. This is noted in the member's *Schedule of Benefits* and the provider's *UnitedHealthcare Administrative Guide* (found at uhcprovider.com). The member can obtain information on this process by calling the telephone number shown on their ID card. Members can also access this information online through myuhc.com. **Out-of-Network Requests:** 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 The purpose of this process is to provide timely and consistent determinations and notices for all out of network coverage requests. 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.
H. The carrier's process for monitoring access to in-network physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at its participating facilities.	**Access Standards and Measures** The plans measure member accessibility to medical services and member services against at least one of the standards for each type of service shown in the table below.

Type of Service	Standards/Measures
Preventive Care	Within 4 Weeks Percentage of members responding through member satisfaction survey that they get an appointment for routine care as soon as needed. * *Access complaint volume threshold per 1000 members
Regular/Routine Care Appointment	Within 14 days Percentage of members responding through a member satisfaction survey that an appointment for routine care was obtained as soon as needed.* *Access complaint volume threshold per 1000 members
Urgent Care Appointment	Same day Percentage of members responding through a member satisfaction survey that an appointment for care needed right away was obtained as soon as needed.* *Access complaint volume threshold per 1000 members
After-Hours Care	24 hours/7 days a week for primary care Percentage of members responding through a member satisfaction survey that they were able to access after-hours care as soon as needed.* Percentage of member responding through a member satisfaction survey that an appointment for care needed right away was obtained as soon as needed.* *Access complaint volume threshold per 1000 members

High Volume and High Impact Specialty Care	Percentage of members responding through a member satisfaction survey that they were able to access specialty care as soon as needed.* Percentage of requests for out-of-network (OON) services by HVS and HIS specialist practitioner types fall within established variance range from benchmark (regional performance) Average days to wait for new patient and established patient appointment times as reported by survey of practitioners. *Access complaint volume threshold per 1000 members

3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

Evaluation Criteria	Response
A. Location(s)/availability of a provider directory(ies), how often it is updated, and availability in other languages [A provider directory is a comprehensive listing, made available to covered persons and primary care providers, of the carrier's network of participating providers and facilities]	Members have access to myuhc.com a website with online directories to search for doctors, clinics, or facilities, with the option to print results. Additionally, there is a link for native language choices. This information is updated on a continual basis with the date of last update in lower left corner of page.
B. Full description of the referral process, including at a minimum: 1. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health benefit plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers. 2. A process for timely referrals for access to specialty care. 3. A process for expediting the referral process when indicated by medical condition. 4. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse. 5. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse. 6. A health benefit plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees;	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. **Specialist Referral:** The member's assigned PCP coordinates the member's care and submits electronic referrals to UnitedHealthcare before the member sees another network physician. If a network specialist identifies the need for a member to see another specialist, the specialist must ask the member's PCP, who decides whether or not to issue an additional referral. **Referral Process:** Notification to the member should complete in a timely manner, not to exceed five business days of a request for non-urgent care, or 72 hours of a request for urgent care. When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. **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. The purpose of this 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 covered consumer 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.
C. The carrier's process for allowing members to access services outside the network when necessary.	• **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.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

Evaluation Criteria	Response
A. In the network access plan for each network offered, a carrier shall explain its method for informing covered persons of the plan's services and features through disclosures and notices to policyholders.	The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits including but not limited to: • Member rights and responsibilities • QI Program activities and accomplishments • Case management programs • Disease Management programs • Financial incentives related to utilization management (UM decisions) • Benefits coverage, exclusions, restrictions and costs of care • Pharmacy and UM procedures and benefits • Notification requirements and medical services • Evaluation of new technology • Finding a network physician or hospital • Obtaining routine, preventive and specialty care; urgent, ER and hospital; after-hours, out of state/area and behavioral care • Looking up and submitting claims, obtaining and ID card • How to submit a complaint or appeal • External appeal processes • Language assistance and TDD/TYY services • Notice of Privacy Practices Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide, Quick Start Guide, and the annual Rights and Resource Disclosure Booklet (ARRD). Members also have access to myuhc.com, a website with resources for accessing personal health records, finding physicians, and encouraging healthy behaviors.

B. Required disclosures, pursuant to § 10-16-704(9), C.R.S., shall include: 1. The carrier's grievance procedures, which shall be in conformance with Division regulations concerning prompt investigation of health claims involving utilization review and grievance procedures; 2. The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available; 3. The carrier's procedures for providing and approving emergency and non-emergency medical care; 4. The carrier's process for choosing and changing network providers; 5. The carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; 6. The carrier's documented process to identify the potential needs of special populations; and 7. The carrier's methods for assessing the health care needs of covered persons, tracking, and assessing clinical outcomes from network services, assessing needs on an on-going basis, assessing the needs of diverse populations, and evaluating consumer satisfaction with services provided.	Members can file a complaint/grievance by calling the telephone number shown on their ID card. Members can also access this information online through myuhc.com and in their plan specific *Certificate of Coverage* or *Evidence of Coverage* documents received upon enrollment. Representatives are available to take calls during regular business hours, Monday through Friday. If a member would rather send their complaint in writing, the representative can provide them with the address. If the representative cannot resolve the issue over the phone, he/she can help the member prepare and submit a written complaint. The member will be notified of the decision regarding their complaint within 60 days of receiving it. A member can file a written request for an appeal if they disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination. Members can find out how to file an appeal by calling the telephone number shown on their ID card. Members can also access this information online through myuhc.com and in their plan specific *Certificate of Coverage* or *Evidence of Coverage* documents received upon enrollment. Their written request should include: the patient's name and the identification number from the ID card, the date(s) of medical service(s), the provider's name, the reason you believe the claim should be paid, any documentation or other written information to support your request for claim payment. The first appeal request must be submitted to UnitedHealthcare within 180 days after receipt of the denial of a pre-service request for Benefits or the claim denial. Once the appeal is received, it will be reviewed by a qualified individual or physician (clinical reviews). For appeals of pre-service requests for Benefits, the first level appeal will be completed within 15 days from receipt. For appeals of post-service claims, the first level appeal will be completed within 30 days from receipt of a request for appeal of a denied claim. If the member is not satisfied with the first level appeal decision, they can request an independent external review or if the Benefit denial involves an Adverse Determination based on clinical criteria, a Rescission, or a denial of coverage based on an initial eligibility determination, they have the right to request a voluntary second level appeal. A voluntary second level appeal request must be submitted within 60 days for from receipt of the first level appeal decision. The voluntary second level appeal review will take place within 15 days of receipt (for pre-service requests) or 30 days of receipt (for post-service claims) of the request by a health care professional who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or outcome of the review. Members have the right to appear in person or by telephone conference at the voluntary second level appeal review meeting and will be notified in writing at least 20 days in advance of the date of the meeting. Within 7 days of completion of the review meeting, but no later than 15 days (for pre-service requests) or 30 days of receipt (for post-service claims) of receipt of the voluntary second level appeal request, the member will receive written notification of the decision on your appeal. Urgent appeals are available if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. The member or their physician should call the telephone number shown on their ID card as soon as possible. The member will be provided a written or electronic

	determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the condition. If more information is needed from their Physician to make a decision, the member will be notified of the decision by the end of the next business day following receipt of the required information. If additional information is needed from the member to make a decision, they will be notified of the information required within 24 hours after the urgent request is received. The member then has 48 hours to provide the requested information. The member will be notified of a benefit determination no later than 48 hours after: receipt of the requested information; or the end of the 48-hour period within which the member provided the additional information if the information is not received within that time. The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries. The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits, including finding a network physician. The *Welcome Guide* and the *Getting The Most From Your Health Care Coverage* document within the *Annual Rights and Resource Disclosure* notice information provides information and resources for selecting a network provider. Detailed information regarding covered benefits and making Primary Care Physician changes can be found in the member's *Schedule of Benefits*. Covered persons have access to all covered services in and out-of-network in all circumstances. Emergency care is a covered service and is accessible in and out-of-network in all circumstances. Members receive plan specific *Certificate of Coverage* or *Evidence of Coverage* documents upon enrollment. Documents can also be accessed online at www.myuhc.com. Information is also listed on the back of the member's ID card. UnitedHealthcare is committed to ensuring that our website and mobile applications are accessible to individuals with disabilities. Members who need assistance using website or mobile application, or assistance with a PDF, can call toll-free at 1-844-386-7491. TTY or RTT users may dial 711. Members can also call the toll-free member phone number on your health plan ID card for assistance. For assistance with mobile applications members can contact the support number identified in the mobile application. A member who gets insurance through their employer can call 1-877-844-4999 / TTY or RTT 711 for 24/7. UnitedHealthcare utilizes several tools to assist with the translation and interpreter services in languages other than English for individuals with limited English proficiency including the Health Plan Notices of Privacy Practices contains notification of availability of free translation services and the Member in Need of Communication Accommodation SOP contains instructions for our Customer Service Representatives to assist members in need of Deaf/Blind/ASL assistance. Members have access to free services to help communicate with UnitedHealthcare, such as, letters in other languages or large print, interpreter services, request language assistance by calling the telephone number shown on their ID card. Members can also access this information online through myuhc.com.

	The UnitedHealthcare Provider Directories are resources for members with special needs. Providers who are multilingual or employ multilingual front office staff; by languages spoken by providers and front office staff can be filtered on in the directory search and under each provider profile. There is also a filter for extended hours, weekend and evening appointments. The provider profile in the directory also has an accessibility section for exterior building, bathrooms and parking.

5. PLANS FOR COORDINATION AND CONTINUITY OF CARE

Evaluation Criteria	Page Number for Supporting Documentation
A. The carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers.	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. UnitedHealthcare members can locate the Continuity of Care information through their portal, which explains how to apply for continuity of care for new or existing members.
B. The carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources.	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. UnitedHealthcare members can locate the Continuity of Care information through their portal, which explains how to apply for continuity of care for new or existing members.
C. The carrier's documented process for ensuring appropriate discharge planning.	**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. TCM can be accessed by contacting UnitedHealthcare via the provider portal.
D. The carrier's process for enabling covered persons to change primary care providers.	The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits, including finding a network physician. The *Welcome Guide* and the *Getting The Most From Your Health Care Coverage* document within the *Annual Rights and Resource Disclosure* notice information provides information and resources for selecting a network provider. Detailed information regarding covered benefits and making Primary Care Physician changes can be found in the member's *Schedule of Benefits*. As part of UnitedHealthcare's most recent NCQA Corporate survey, detailed instructions and screenshots were included in the myuhc.com demo, showing members how to change their Primary Care Physician selection online.
E. The carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process must include an explanation of how covered persons shall be notified in the case of a provider contract termination, the carrier's insolvency, or of any other cessation of operations, as well as how policyholders	Members or their providers can request Continuity of Care access if a provider is no longer in-network due to a contact termination. The member can obtain information on this process by calling the telephone number shown on their ID card or online through myuhc.com. This information is also provided in the communication members receive upon the termination of a provider. Providers can locate Continuity of Care information under the Consolidated Appropriations Act (CAA) requirements and in the *UnitedHealthcare Administrative Guide: Chapter 2: Provider responsibilities and standards*, both located at uhcprovider.com.

impacted by such events will be transferred to other providers in a timely manner.	UnitedHealthcare's *Provider Administrative Guide* and provider participation agreements include language that addresses 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. Additionally, 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) Medical 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.
F. A carrier must file and make available upon request the fact that the carrier has a "hold harmless" provision in its provider contracts, prohibiting contracted providers from balance-billing covered persons in the event of the carrier's insolvency or other inability to continue operations in compliance with § 10-16-705(3), C.R.S. Network access plan requirements and demonstrations.	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) Medical 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.

PLANS FOR COORDINATION AND CONTINUITY OF CARE

Coordination Activities

An annual quantitative and qualitative analysis is conducted to review the continuity and coordination of medical care provided to UnitedHealthcare members across settings and or during transitions of care

The scope of activities includes managing and coordinating aspects of medically necessary care between inpatient and various outpatient settings and between primary physicians and specialists through care coordination and providing communications to bridge gaps between treating practitioners and providers. The primary activities may include but are not limited to:

- Prescription of controlled substances
- Member satisfaction with continuity and coordination of medical care
- Provider satisfaction with coordination of medical care
- Steerage to transplant centers of excellence
- Continuity of care between dialysis centers and nephrologist
- Postpartum care
- Transitional Case Management Opportunity
- Monitoring of Quality of Care Complaints

UnitedHealthcare staff partner with OptumHealth and OptumRx to identify gaps and develop strategies to act on opportunities to improve continuity and coordination of medical care.

Continuity of Care

UnitedHealthcare's *Provider Administrative Guide* and provider participation agreements include language that addresses 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. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations.

Ongoing Monitoring

In accordance with UnitedHealthcare's *Availability of Practitioners and Providers* policy, 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 members.

Needs of Special Populations

The Health Equity Services (HES) program was established to help address health disparities. The HES program helps reduce health disparities by improving our culturally sensitive initiatives that promote health and prevent avoidable health care cost. To accomplish this, the HES program operates with four key focus areas:

- Collecting data to better understand our membership and their cultural characteristics
- Identifying gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language
- Growing multicultural capabilities to enhance the member experience

We continue to significantly enhance our HES programs and offerings through:

- Employee training for more insight about providing services to our members from diverse cultural backgrounds
- Customized member outreach and communication
- Enhanced data analytics to address identified health disparities

The Health Equity Services program completed an enterprise compliance assessment of the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and is at industry standard or better for all 15 standards. Despite being at industry standard or better for all CLAS standards, we continue to plan and implement improvements that will further our efforts to reduce identified member health outcome disparities.

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

- CAHPS® data
- Member Satisfaction Survey Data
- U.S. Census Data
- Network Database (NDB)
- Enrollment Data
- Medicare/Medicaid eligibility files
- Focus Groups
- American Community survey
- Other Sources As Required Or Needed

To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability.

Health Needs Assessment

UnitedHealthcare's *Assessing Member Experience* policy is to assess member experience with its services and programs, at least annually, and identify areas for potential improvement. When opportunities for improvement are identified, actions are taken to improve member experience.

Primary data collection sources include member complaints and appeals, UM consumer concerns, and member experience surveys. Member experience surveys may include, but are not limited to:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS®)
- Key Member Indicators (KMI) Survey

- Member Focus Groups
- Complex Case Management Surveys
- Disease Management Surveys
- State, Federal and Regulatory Surveys

Telehealth

"Telehealth" means a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies to facilitate the assessment, diagnosis, consultation, treatment, education, care management or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. This term includes;

(A) Synchronous interactions
(B) Store-and-forward transfers and
(C) Services provided through HIPAA compliant interactive audio-visual communication or the use of a HIPAA compliant application via a cellular telephone

Telehealth" does not include delivery of health care services via:

Voice-only telephone communication or text messaging;
(A) Facsimile machine; or
(B) Electronic mail systems
(C) Electronic mail systems.

Telehealth Services Coverage is provided for "Telehealth" services the same as other Covered Health Care Services. UnitedHealthcare does not currently use telemedicine services to fulfill the provider network access standards.