Network Access Plan for West Virginia

Optimum Choice Inc (OCI)

Overview: This access plan is for Optimum West Virginia network. Optimum Choice, Inc. (OCI) is a subsidiary of UnitedHealthcare (UHC). Within this document, reference to Optimum Choice is used interchangeably with UHC/UnitedHealthcare. The West Virginia Office of the Insurance Commissioner has licensed OCI as an insurance company issuing health maintenance organization (HMO) plans. The Optimum Choice network requires PCP selection. The PCP is responsible for coordinating care and issuing referrals when appropriate. The Optimum Choice network offers plans statewide in West Virginia. Per West Virginia Code: §33-55-3, we are required as an issuer to create an access plan for our networks. This access plan describes our strategy, policies, and procedures to create, maintain and administer an adequate network.

2024 WEST VIRGINIA CODE: §33-55-3: (f) The access plan shall describe or contain at least the following:	**Carrier Responses:**
1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable; tele-med policy	**Virtual Visit Provider vs. Telemedicine Provider** Telemedicine services are provided through our UnitedHealthcare network physicians that have the resources to provide telemedicine services. Virtual visits are provided by entities AmWell, Teladoc® and Dr+® on Demand and Optum Virtual Care. For purposes of telemedical benefit, an "originating site": includes, but is not limited to a hospital; Rural health clinic; Federally qualified health center; Physician's office; Community mental health center; Skilled nursing facility; Renal dialysis center; or a site where public health care services are provided or where the patient resides. For telemedical health care services not related to the treatment of diabetes, "telemedical" coverage is available when provided by a health care professional to a patient who is at an originating site, using synchronous two-way interactive video conferencing if: • The plan provides coverage of health care service when provided in person by a health professional. • The health service is medically necessary. • The telemedical health care service relates to a specific patient; and • One of the participants in the telemedical health service is a representative of an academic health center. "Health Professional" means a person licensed, certified, or registered in West Virginia to provide health care services or supplies. For telemedical health care services provided in connection with the treatment of diabetes, "telemedical" coverage is available when provided by a health care professional to a patient, parent or guardian of a patient or another health care professional acting on the patient's behalf, using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards, including but not limited to video,

	audio, voice-over-internet protocol or transmission of telemetry. Health professionals offering telemedicine health care services are treated as any other UnitedHealthcare Network participating provider. In addition to requiring these providers to comply with all applicable laws and regulations, all contracted providers are obligated to adopt UnitedHealthcare Network protocols and administrative procedures. Telemedical and Virtual Visit providers are subject to the same credentialing requirements as any other provider under United's Credentialing Plan. While specific efforts will vary by provider group, each of UHC's contracted 24/7 Virtual Visit provider groups has set Diversity, Equity, and Inclusion initiatives in place to drive provider education and promote awareness of individual patient needs. Such initiatives include but are not limited to culturally and linguistically appropriate services (CLAS) policies, staff social workers focused on social determinants of health (SDOH), and cultural competency training. • Members may search for providers via the Optum Behavioral liveandworkwell.com online provider directory or myuhc.com. Members will choose a provider from the directory and call to set up an appointment. • Telemental behavioral benefit is separate from UnitedHealthcare's virtual visits (medical) model. • Telemental health visits are covered and are considered the same as a behavioral office visit. • Members will have the same out-of-pocket cost whether they see the psychologist/ psychiatrist in-office or via video-enabled capabilities. • The Telemental health network is available in all 50 states. Services are delivered by a network provider licensed within the member's state and may include psychiatrists, psychologists, and other practitioners licensed in behavioral health such as nurse practitioners and master level clinicians. **Telemental Health** Members who have behavioral health coverage through Optum are eligible to use virtual visits as a form of therapy. UnitedHealthcare members have the option of seeing a behavioral health provider via video-enabled capabilities:

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;	**Referrals and Prior Authorizations** UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the UnitedHealthcare Provider Administrative Guide available on uhcprovider.com. Participating providers are strongly encouraged to use in network physicians and facilities, but UHC does 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. The referral process, advance notification process, and prior authorization process are separate processes. All care providers must follow the notification and/or prior authorization requirements when providing a service that requires a notification and/or prior authorization. A referral does not replace the advance notification or prior authorization process. Referrals must be submitted by the member's PCP or by a PCP within the same tax ID number. Specialists cannot enter referrals in the UnitedHealthcare system. They must ask the member's PCP to enter a referral. Referrals are accepted to network physicians only. The member's assigned PCP must submit referrals electronically, prior to the service being rendered. The PCP determines the number of visits, up to the allowed max, needed for each referral in a 6-month period. They may submit another referral after the member uses the visits or they expire. Services done under a new referral are established patient visits. • Referrals are only valid for the authorized number of visits or through the indicated referral end date. Any unused visits are not valid after the end date. • If a referral is no longer valid, but the member requires additional care, the member or specialist must contact the member's PCP to request a new referral. The PCP then decides whether to issue an additional referral. • If a network specialist sees a need for a member to go to another specialist, the specialist must ask the member's PCP to issue an additional referral. Services provided when a referral is not on file may impact the provider reimbursement and member benefits. This varies by product. Providers will need to refer to the product specific details on uhcprovider.com for additional information. **Mental Health Referral Policy** Optum aligns the authorization requirements for the behavioral benefit with those of the medical/surgical plan. For most plans, prior authorization is required for a small range of

	planned behavioral health services covered under the outpatient benefit, although plan-specific requirements may vary. Behavioral Health notification and prior authorization requirements for mental health and substance abuse services are available on providerexpress.com. If a member's plan includes out-of-network coverage, Optum will authorize and review those services using the same clinical criteria and procedures as with in-network services. There is nothing more restrictive or different in managing in-network vs out-of-network services. **Out of Network Referral and Continuity of 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. • Continuity of Care (CoC): A request for CoC is based on a benefit which allows a covered consumer to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The

	consumer 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. **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.

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans	**Network Monitoring and Adequacy** 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 evaluations of Availability (geographic, numeric, cultural and linguistic availability of practitioners), Accessibility (access to appointments based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) and analysis of requests for out of network (OON) specialty care services. An assessment of complaints and appeals related to access to care is integrated into the analysis. UnitedHealthcare has policies and procedures in place to ensure accessibility standards are met, and Quality Improvement Programs to provide effective monitoring and evaluation of patient care and services provided by practitioners and providers for compatibility with evidence-based medicine guidelines. In addition, if a member needs services from a unique hospital-based health system that is not part of the Choice network, UHC will work with those providers to ensure the member may see that out of network provider at in-network and be held harmless from billed charges above their Choice cost share. UnitedHealthcare monitors networks for network adequacy weekly. UnitedHealthcare leverages Quest Analytics to determine if the minimum number of providers/facilities and meeting maximum time/distance requirements are met. If the network is found to be inadequate for any service area (county) and specialty, network teams identify providers available to close the inadequacy. Once the provider is contracted and loaded to the source systems, the updated network adequacy assessment will be reflected. This process is cyclical and dynamic as provider term and contract. Monitoring access to specialist providers of emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals is as follows: A. Performance against appointment access standards are measured by analysis of: • CAHPS® questions/supplemental questions • Key Member Indicators Survey questions • Qualified Health Plan Survey (QHP) questions • Primary Care Practitioner and Specialty care Practitioner Accessibility Surveys • PCP After-hours Access Survey • Member access complaints • OON service requests and claim utilization

	• Behavioral Health member experience survey questions, complaints, treatment record reviews, appointment tracking and claims data B. Member service telephone access performance is measured with results from reports generated by Customer Care (service) department. Telephone access is evaluated on an annual basis against standards at the corporate level for UnitedHealthcare Employer and Individual (E&I). Provider Network Factors UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as, any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We accept requests from employers, members, and providers to accommodate needs and preferences. 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. Access to specialty services such as emergency, anesthesiology, radiology, hospitalist, pathology and laboratory care services at participating hospitals are evaluated same as other participating provider types. Additionally, facility contracts include terms indicating facilities will make reasonable efforts to ensure all facility-based providers participate in UnitedHealthcare's network. Network providers may be found throughout the state of West Virginia. A list of Network providers within your Service Area can be obtained by visiting the UnitedHealthcare provider lookup website at www.uhc.com/find-a-physician. If you would like a printed copy of providers, we will send it free of charge upon request.

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select providers;	**Network Description** The Optimum Choice network supports plan designs that permit access to in-network providers and facilities, as well as plan designs that include out of network coverage. Members are encouraged to select a Primary Care Physician (PCP), who may help coordinate necessary care needs. The member can elect medical services that fit their current medical needs without the guidance of their PCP. To ensure all members have access to providers who meet their needs, we look at the number and distribution of network access points in specific areas. We make outreach to providers as needed in order to recruit them to our network. We also accept requests from employers, members, and providers to accommodate needs and preferences. **Credentialing/Recredentialing** All participating practitioners and providers require credentialing and recredentialing according to accrediting entities and state and federal authorities. Practitioner verification and review includes, but is not limited to, education and training, board certification status, license status, hospital privileges, and malpractice and sanction history including primary source verification where required by accreditation or regulatory requirements. All practitioners undergoing initial credentialing and triennial recredentialing are reviewed and approved by the National Credentialing Committee. **UnitedHealth Premium® Designation Program** The UnitedHealth Premium® Designation program provides physician designations based on quality and cost-efficient care criteria to help members make more informed choices for their medical care. Physicians may use these designations when referring patients to other physicians. The Premium program evaluates physicians in various specialties using evidence-based medicine and national standardized measures for quality and cost efficiency. Physician designations are displayed on UnitedHealthcare's provider directory on myuhc.com. The program evaluates more than 370,000 physicians across 45 states. Quality is the primary program measurement and is evaluated using national standardized measures. The cost efficiency criteria compare a physician's actual allowed costs to case-mix adjusted benchmarks for physicians in the same specialty and geographic area. Physicians are evaluated at least every two years. **UnitedHealthcare Networks ("UHN")** UHN develops and maintains comprehensive provider networks that are accessible nationally to insured members

	covered by affiliated companies, including members residing in West Virginia. UHN has primary responsibility for developing networks for the following categories of covered health services: • Physician services, including consultation and referral • Hospital inpatient and ambulatory care services • Diagnostic laboratory and therapeutic radiology services • Home Health Services • Nursing Facility • Hospice • Emergency health care services including ambulances; and • Preventive health services In addition to UHN, the Company utilizes the following affiliated companies for specialty care services and other basic health care services that may be covered pursuant to an insurance policy issued in West Virginia: • The statewide mental health or substance abuse treatment Network is administered through United Behavioral Health (Optum). • OptumHealth Care Solutions, Inc. arranges covered acupuncture, physical therapy, occupational therapy, and speech therapy services through its contracted network of licensed and credentialed providers. • Optum Rx, Inc. oversees the dispensing of covered pharmacy benefits though its mail order and retail pharmacy networks. • Dental Benefit Providers, Inc. arranges dental services for children and adults through its contracted network of licensed and credentialed providers. • Spectera Vision, Inc. arranges vision services for children and adults through its contracted network of licensed and credentialed providers. UnitedHealthcare has established quantifiable and measurable standards as outlined in our **Availability of Practitioners and Providers Policy**. Our plans ensure that services are geographically accessible and are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services.

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;	**Needs of Special Populations** In 2010, 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 In 2019 and 2020, we are significantly enhancing 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. In addition, literacy needs may

	be measured for Marketplace. 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. 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 UnitedHealthcare contracts with Essential Community Providers (ECP) in an effort to have a network with adequate coverage for enrollees in the service area. We have several ECPs in our network throughout West Virginia. We will continue to monitor the adequacy and availability of 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.

(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;	**Accessing Members Needs** 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. 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, searching the provider directory, and encouraging healthy behaviors. 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. Member notifications include continuity of care information and we direct members to contact us or utilize the online directory for assistance in locating other in-network providers. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations.
(7) The health carrier's method of informing covered persons of the plan's covered services and features, including, but not limited to:	**Supporting Customer Needs** 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

(A) The plan's grievance and appeals procedures;	**Appeals and Complaint Procedures** • Covered persons are provided with a **Certificate of Coverage** when coverage is initially purchased, which includes a description of the coverage and grievance procedure. Please see COC23-OCI-2018-LG-WV, Section 6: Questions, Complaints and Appeals on page 54-58. In addition, the appeals procedure is included with any adverse determination.
(B) Its process for choosing and changing providers	**Process for choosing and changing providers** Covered persons are directed in the Certificate of Coverage to choose their provider. The language of the COC states: • It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver. procedure. Please see COC23-OCI-2018-LG-WV, Your Responsibilities: Choose Your Physician on page 3.

(C) Its process for updating its provider directories for each of its network plans;	**Provider Directory Maintenance** The UnitedHealthcare (UHC) process for updating its provider directories is the same for each network plan. See Provider Directory Maintenance Schedule policy, below. Both members and consumers alike may access the online provider directory by using the link provided, also below. Providers are required to attest to their demographic information every 120 days for both online and paper directory purposes. Primary methods used for attestation purposes are via CAQH (Council for Affordable Quality Healthcare), My Practice Profile (UHC's cloud-based digital platform) for non-delegated groups, an assigned UHC roster manager for delegated groups, and a UHC Provider Verification Outreach (PVO) team that conducts demographic verification via outbound call campaigns. Changes made to demographic information are updated in UHC's source system(s), which subsequently displays to the directory within 3-5 days as part of the refresh cycle. The online UHC directory is updated five times weekly to reflect any new or updated providers, while the paper directory is printed twice annually (April and September), with exceptions to meet individual state requirements as may be outlined. Providers may access the provider directory via myuhc.com or uhcprovider.com as well. By accessing the provider directory through uhcprovider.com, providers have the option to conduct a general search for participating physicians, hospitals, laboratories, and other health care professionals or complete a Plan Physician Directory search for health professionals that participate in a specific member's benefit plan. The following filters are available for narrowing the provider search: • Location • Distance from Location • Preferred Providers • Patient Reviews • Specialty • Language • Gender • Accepting Patient Status • Hospital Affiliations **Reporting Inaccurate Information** Members, non-members, and providers may report potential inaccurate, incomplete, or misleading information by using the "Report Incorrect Information" links found on myuhc.com or uhcprovider.com on the Provider's detail page, or by sending an email to

	provider_directory_invalid_issues@uhc.com. This email box is for individuals to report potential inaccuracies for demographic (address, phone, etc.) information in the online or paper directories. Reporting issues via this mailbox will result in an outreach to the provider's office to verify all directory demographic data. Updates or changes to demographic data are made within 30 days, or within individual state regulations if different. Individuals can also report or submit a complaint, related to potential inaccuracies via phone. UHC Members should call the number on the back of their ID card, and non-UHC members can call 1-888-638-6613. UHC directories are updated five times weekly to reflect applicable demographic changes for the provider network. Both members and consumers alike may access the provider directory by using the link provided below in a non-authenticated manner. https://connect.werally.com/plans/uhc https://myuhc.com

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and	The UnitedHealthcare Optimum Choice health plans allow members to choose a physician or specialist from the UnitedHealthcare Optimum Choice networks but do not need a referral to receive benefits. • UnitedHealthcare Optimum Choice members must receive care from network care providers for benefits to be covered. There is out-of-network coverage for emergency services only. • UnitedHealthcare Optimum Choice Plus members are covered at a lower benefit level for services provided by out-of-network care providers. Preventive care, including immunizations and preventive exams and health screenings, is covered at 100 percent in our UnitedHealthcare Optimum Choice networks. Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law: • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. • With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
(E) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable;	Providing and approving emergency and specialty care Covered persons are provided with a Certificate of Coverage and Schedule of Benefits when coverage is initially purchased. These documents include a description of the coverage for emergency and other provider services including information regarding services requiring prior authorization.

(8) The health carrier's system for ensuring the coordination and continuity of 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. An out-of-Network physician providing inpatient or outpatient services at a Network health care facility in Oregon may not bill the member for charges above the Allowed Amount unless the member chooses to receive Covered Health Care Services from the out-of-network physician. The Certificate of Coverage advises members of the state's balance billing law and when it applies. Both the member's Explanation of Benefits and the provider's PRA include the following statement that the claim is subject to the state's balance billing law and that the provider is prohibited from balance billing the patient. AN OUT-OF-NETWORK PROVIDER PROVIDED THESE SERVICES AT A NETWORK FACILITY. THE CLAIM WAS PROCESSED USING YOUR NETWORK BENEFITS. DUE TO STATE LAW, THE PROVIDER CANNOT BILL THE PATIENT FOR ANY AMOUNT ABOVE THE CO-PAYMENT, COINSURANCE AND/OR DEDUCTIBLE. If UnitedHealthcare is notified that a provider is attempting to balance bill the member, a letter is sent to the provider reminding them of the law and the prohibition on balance billing. 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.

(A) For covered persons referred to specialty physicians; and	Member Communication: The UHC Member Communications Policy was developed 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 • All available Population Health Management programs, including Case Management and Disease Management Case 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) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;	Needs of Special Population 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 • Improving the patient-centered approach based on member demographics, including a person's age, race, ethnicity and language Growing multicultural capabilities to enhance the member experience The HES programs and offerings include: • 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 • Provider web-based accredited education to promote health equity and the elimination of health-related disparities associated with access to care, utilization of care, presence of disease and health outcomes UnitedHealthcare has multiple national actions in place under the Health Equity Services Program and Health Literacy aimed at addressing the specific cultural, ethnic, racial, and/or linguistic needs of our members. These programs are designed to close disparities in health and health care for various populations through education and communication with members and providers. 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 • Practitioner Network Data • Enrollment Data • Medicare/Medicaid eligibility files • Focus Groups • American Community survey • Member Complaints • 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. In addition, literacy needs may

	be measured for Marketplace, if applicable. Health Needs Assessment UnitedHealthcare conducts an annual assessment of member experience to identify potential issues and develop plans to correct process deficiencies and improve outcomes. The assessment is accomplished using an annual analysis of the following categories: 1. Member Reported Complaints and Appeals Data 2. Consumer Assessment of Healthcare Provider and Systems (CAHPS®) 3. Qualified Health Plan Enrollee Experience Survey (QHP) Cultural, Ethnic and Racial Needs: Analysis of cultural, ethnic, and racial needs was completed when the race/ethnicity percentage of the population was more than 10% of the total population of a given state.
(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;	Members may change their PCP via myuhc.com or may contact the customer care number on their ID card. The process for changing a PCP is communicated annually via the Annual Rights and Resource Disclosure.

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner	**Provider Terminations** Network Management and internal business partners meet at least monthly to discuss potential provider terminations. Monitoring includes medical groups, hospitals, hospital-based physicians, and ancillary providers when UnitedHealthcare has initiated or been notified of a termination. Policies are in place to notify members when a medical group, hospital, or ancillary provider, for any reason, leaves the insurer's network, and when UHC is informed of and upon confirmation by the insurer. When UHC is notified timely, affected members will be mailed notification 30 days prior to the effective date of the termination. Members are informed of their continuity of care rights. **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.
(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals; and	Monitoring access to specialist providers of emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals is as follows: A. Performance against appointment access standards are measured by analysis of: • CAHPS® questions/supplemental questions • Key Member Indicators Survey questions • Qualified Health Plan Survey (QHP) questions • Primary Care Practitioner and Specialty care Practitioner Accessibility Surveys • PCP After-hours Access Survey • Member access complaints • OON service requests and claim utilization • Behavioral Health member experience survey questions, complaints, treatment record reviews, appointment tracking and claims data
(12) Any other information required by the commissioner to determine compliance with the provisions of this article.	N/A