Introduction to UnitedHealthcare Dual Complete® (HMO-SNP), offered by UnitedHealthcare Community Plan of Oklahoma

Care Provider Education Session

UnitedHealthcare® Community Plan

Welcome/Agenda

- Mission/Vision
- UnitedHealthcare Dual Complete®
- Member Eligibility and Benefits
- Clinical Program Requirements
- Pharmacy Services
- Doing Business with Us
- Care Provider Resources
- Your Physician Advocate
- Questions

UnitedHealthcare®
Community Plan

Mission and Vision

Our Mission

Our mission is to help people live healthier lives and to help make the health system work better for everyone.

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicare members as well as our members in other government-sponsored health care programs. And to be effective partners with physicians, hospitals and other health care professionals in serving their patients.

What are Dual Special Needs Plans (DSNPs)?

Understanding Special Needs Plans (SNPs)

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- SNP is a Medicare Advantage (MA) coordinated care plan that provides targeted care and services to individuals with unique needs.
- There are three types of SNP plans:
    1. Chronic SNP: For members with severe or disabling chronic conditions, as specified by the Centers for Medicare and Medicaid Services (CMS).
    2. Institutional SNP: For members who require a nursing home level of care
    3. Dual SNP: For members eligible for Medicare and Medicaid

Special Needs Plans (SNPs) Standards

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- SNPs must follow CMS regulations and cover all Medicare Part A (hospital stay) and Part B (doctor's office) benefits and must include Medicare Part D (pharmacy) coverage.
- SNPs must offer clinical programs and special expertise to serve the target population.
- Our Dual Complete Medicare Advantage Program will reimburse eligible claims according to your UnitedHealthcare contractual Medicare Advantage payment appendix.

What is a “Dual” Special Needs Plan (DSNPs)?

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DSNPs must:

- **Limit enrollment** to Medicaid recipients (dually eligible/Medicare-Medicaid Enrollees)
- Provide **Part D** benefits
- Offer **targeted clinical programs**, benefits and services
- Report additional SNP metrics
- **Contract with State Medicaid agency**

DSNPs may:

- **Market year-round** to eligible individuals
- Allow some enrollees to qualify for a Special Election Period (SEP)

Dual SNP Facts

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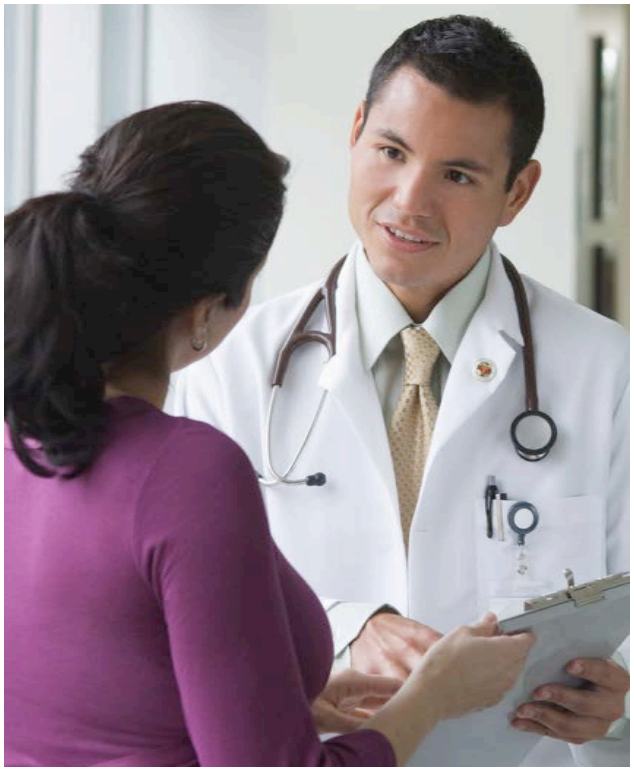
- Nine million Medicare beneficiaries are eligible for both Medicare and Medicaid.
- Dual eligible beneficiaries represent 20 percent of the Medicare population, yet account for more than 31 percent of Medicare expenditures.
- Dual eligible beneficiaries represent 15 percent of Medicaid members, yet account for 39 percent of Medicaid expenditures.
- Average Medicare spending for dual eligible beneficiaries is 1.8 times higher than others with Medicare.

MPR/KFF analysis of CMS's Landscape Files for 2007-2013; values for 2013 reference CMS files released Dec. 15, 2012.
MPR/KFF foundation analysis of CMS Medicare Advantage enrollment files, 2011

UnitedHealthcare Dual Complete® Plan and Benefits

UnitedHealthcare Dual Complete®

UnitedHealthcare Community Plan



Summary

- Network providers deliver Medicare services to the DSNP members who are qualified Medicare beneficiaries.
- UnitedHealthcare Dual Complete Medicare Advantage is the member's primary insurance.
- Medicaid is secondary.

Program Launch Date

- Jan. 1, 2018

Expected Membership

- 2,839

Member Eligibility

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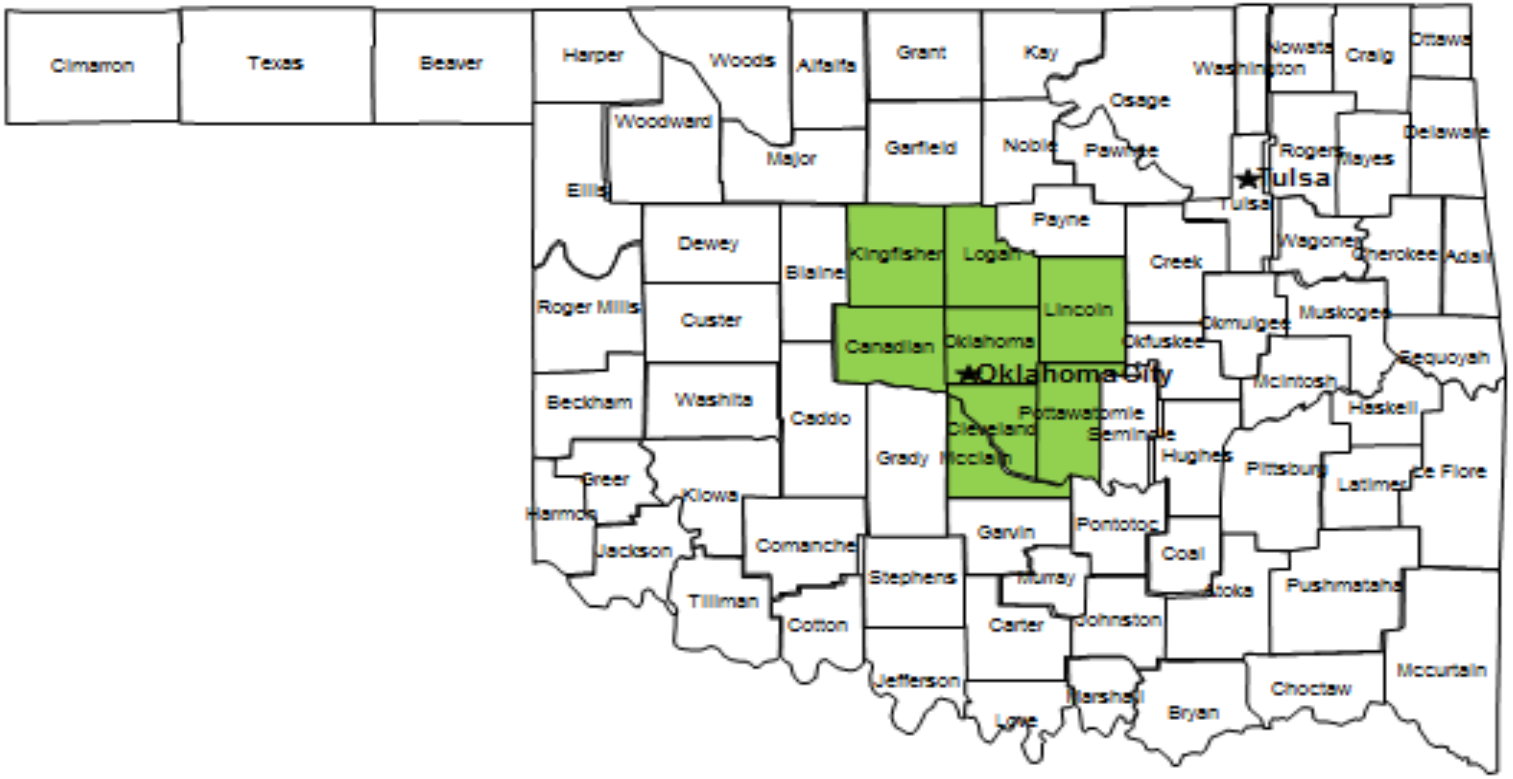
Who is Eligible?

- Must have Medicare Parts A & B
- Reside in the plan service area
- Must not have End Stage Renal Disease (ESRD) - generally
  - Must have specific level of Medicaid eligibility to participate
  - Level of eligibility defined by the local Medicaid agency

UnitedHealthcare conducts a pre-enrollment Medicaid eligibility check to ensure appropriate verification per plan type, before the start of the program.

Service Area Map

UnitedHealthcare Community Plan



Service Area

Our 2018 service area includes the following counties – Canadian, Cleveland, Kingfisher, Lincoln, Logan, McClain, Oklahoma, Pottawatomie.

Oklahoma Medicaid Medical Eligibility Categories

UnitedHealthcare Community Plan

Medicaid Benefits by Medicaid Eligibility Category		
Dual Eligible Category	**Category Description**	**Full Medicaid Benefits**
Qualified Medicare Beneficiary Plus (QMB+)	Member receives Medicaid coverage of Medicare cost-share and is eligible for full Medicaid benefits. **Medicaid pays Part A and Part B premiums, deductibles, coinsurance and copayment amounts.**	Yes
Full Benefits Dual Eligible (FBDE)	Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits	Yes
Specified Low-Income Medicare Beneficiary (SLMB+)	Medicaid pays your Part B premium and provides full Medicaid benefits	Yes
Qualified Medicare Beneficiary (QMB)	Member receives Medicaid coverage of Medicare cost-share and are not eligible for full Medicaid benefits. **Medicaid pays Part A and Part B premiums, deductibles, coinsurance and copayment amounts.**	No

Oklahoma Medicaid Medical Eligibility Categories

UnitedHealthcare Community Plan

Medicaid Benefits by Medicaid Eligibility Category		
Dual Eligible Category	**Category Description**	**Full Medicaid Benefits**
Qualified Disabled and Working Individual (QDWI)	Medicaid pays your Part A premium only.	No - Partial
Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays your Part B premium only.	No - Partial
Qualifying Individual (QI)	Medicaid pays your part B premium only.	No - Partial

Benefit Structure

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Dual Complete Medicare Advantage Parts A, B & D	Dual Complete Medicare Advantage Supplemental	Medicaid Benefits (FFS or Managed)
• Acute visits • Physician services • Skilled nursing facility • Acute home health • Durable medical equipment • Drug coverage • Behavioral Health	• Over-the-counter catalog • Comprehensive dental • Routine vision • Routine hearing/hearing aid • Routine transportation • NurseLine • Acupuncture • Chiropractor	• Medicare cost share covered for all members • Additional coverage beyond Medicare limits • Additional Medicaid benefits

Benefit Structure – Deductible Overview

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- All eligible members have a **Part B** (physician services, outpatient care, durable medical equipment, home health services, and many preventive services) **deductible of $183** prior to the program benefits beginning.
    - **QMB+, FDBE and SLMB+:** have full Medicaid benefits, the State of OK Medicaid agency **is responsible for the** deductible portion of a health care claim.
    - **QMB:** do not have full Medicaid benefits but because of their eligibility status, the State of OK Medicaid agency **is responsible for the** deductible portion of a health care claim
    - **SLMB, QDWI, QI:** have partial Medicaid benefits and the State of OK Medicaid **will not reimburse** the participating provider for the deductible portion of a health care claim.
        - Providers are allowed to seek reimbursement from these category of members for the deductible portion**.**
- **Reminder:** care providers should submit the secondary payment portion of the claim to the Medicaid agency for all eligible and active dual members.

Medicare Advantage Supplemental Benefits

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- We cover preventative services at no **additional** cost to our members and offer assistance with coordination of Medicaid fee-for-service benefits.
- Covered services and programs that may be covered at no additional cost to the member:
  - **Over-the-Counter (OTC) Medication**: Catalog credit of $65/quarter, $260/year; annual expiration
  - **Dental:** $1,500 annually; covers exams, x-rays, cleanings, fillings, crowns, periodontal services, extractions, oral surgery and more
  - **Vision:** Annual exam and eyewear allowance of $100 every year
  - **Hearing:** Annual exam and hearing aid allowance of $1,000 every two years

Other [redacted] Benefits

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- **Transportation: 24** one-way trips for health care visits and prescriptions
- **Acupuncture:** 10 visits combined with Chiropractic for $0 per visit
- **Chiropractic:** 10 visits combined with Acupuncture for $0 per visit
- **NurseLine[SM1]:** A phone service staffed by registered nurses who can help provide answers to health questions 24 hours a day, seven days a week

For a list of additional DSNP member Medicaid benefits available through the state, please visit: okhca.org/providers.aspx?id=45.

[1]This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Behavioral Health Benefits

United Healthcare Dual Complete® SNP program provides a full suite of Behavioral Health benefits. **These services must be provided by a Medicare eligible provider.**

- Acute inpatient hospital for Mental Health and Substance Use Disorder (SUD) (Follow Medicare Hospital days rules)
- Inpatient free-standing psychiatric facility (190 **lifetime** days)
- MH/SUD Partial Hospitalization (PHP)
- MH/SUD Intensive Outpatient (IOP)
- Electroconvulsive Therapy (ECT)
- Transmagnetic Stimulation (TMS)
- Psychological Testing
- Home Health
- Standard/Routine Outpatient (CPT Codes)

- We use Medicare Coverage Summaries, if available, for MNC determination.

Reimbursement Flow for Providers

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- **Example of possible reimbursement – will depend on exact services provided.**

- **HMO-SNP*:** 80% coverage – payable based off of the contracted Medicare Advantage payment appendix.

- **Medicaid:** 20% co-insurance. *Payment from primary insurer may be greater than Medicaid allowable.*

- **Final Reimbursement**
- **Providers may not attempt to collect additional reimbursement from DSNP members whose Medicaid benefits cover all Medicare associated cost sharing components.**

- * Part B deductible requirement of $183 is applied on applicable services prior to the 80% benefit design being applied.

Verifying Member Eligibility and Benefits

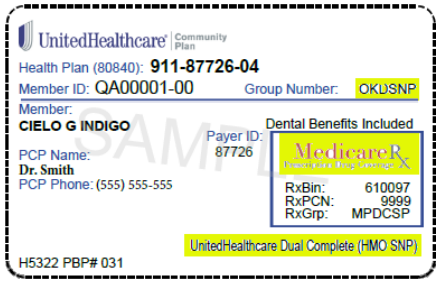
UnitedHealthcare Community Plan

Before providing services, please verify member eligibility.

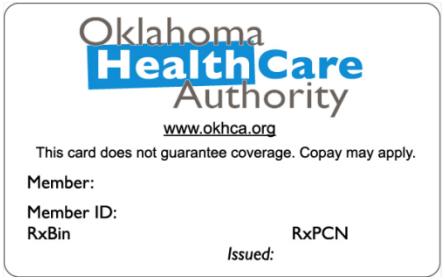
- Link > eligibilityLINK application
  - If you aren't registered yet, go to UHCprovider.com and select "New User" to begin registration.
- Call Provider Services at 844-368-7150 or call the number on the back of the member's ID card.
- Always check benefits before providing services to a UnitedHealthcare Community Plan member.

Member ID Cards

- Dual Complete Medicare Advantage members have one ID card for their Medicare benefits and a separate ID card for their Medicaid benefits (managed Medicaid and/or State program.)
- Check the member's ID card at each visit and copy both sides of the ID card for your files.
- Member ID cards can also be viewed online using the Eligibility & Benefits application on Link.



Medicare benefits – (Parts A, B & D)
Managed by UnitedHealthcare

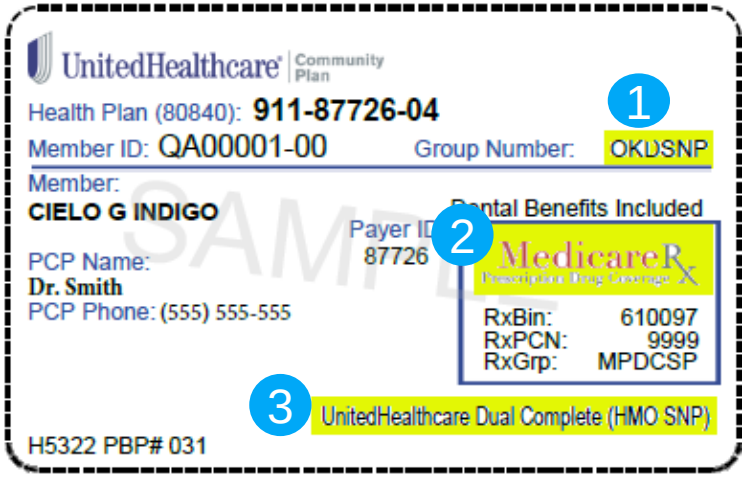


State – Medicaid benefits
(including Medicare cost-sharing)

Sample ID Cards are for Illustration only. Actual cards may vary.

Member ID Card

UnitedHealthcare Community Plan



1. **Group Number:** Two digit state abbreviation and **DSNP**
2. **Pharmacy:** Medicare Rx
3. **Medicare reference -** Medicare limits apply**.**

4. Provider Reference – online resources available at UHCprovider.com (*UnitedHealthcareonline.com is in the process of being decommissioned.)*

5. Medicare reference - Medicare Community Plan

Sample ID Cards are for Illustration only. Actual cards may vary.

Member Cost Sharing Levels

UnitedHealthcare Community Plan

Medicaid Benefits by Medicaid Eligibility Category				
Dual Eligible	Full Medicaid	Medicaid coverage of Medicare Premiums		
		Part A Premium	Part B Premium	Part D Premium*
QMB+	Yes	Yes	Yes	No
SLMB+	Yes	Yes	Yes	No
QMB	No	Yes	Yes	No
QDWI	No	Yes	No	No
SLMB	No	No	Yes	No
QI	No	No	Yes	No

* Members may qualify for Pharmacy (Part D) Low Income Subsidy (LIS), member for Extra Help to cover their Part D premiums and Part D related out-of-pocket costs

Member Cost Sharing Levels (cont'd)

UnitedHealthcare Community Plan

All member cost sharing in UnitedHealthcare Dual Complete ® Medicare Advantage depends on the members' level of dual eligibility.

- Some members may have out-of-pocket costs for premiums, copayments, deductibles and coinsurance.

- All members have either full or partial Medicaid coverage.
  - **QMB+, FDBE and SLMB+:** have full Medicaid benefits, the State of OK Medicaid agency **is responsible for the** deductible portion of a health care claim.
  - **QMB:** do not have full Medicaid benefits but because of their eligibility status, the State of OK Medicaid agency **is responsible for the** deductible portion of a health care claim
  - **SLMB, QDWI, QI:** have partial Medicaid benefits and the State of OK Medicaid **will not reimburse** the participating provider for the deductible portion of a health care claim.
    - Providers are allowed to seek reimbursement from these category of members for the deductible portion**.**

- **Reminder:** care providers should submit the secondary payment portion of the claim to the Medicaid agency for all eligible and active dual members.

Cost Sharing Policy

Provider may not bill, charge, collect a deposit from, seek payment or reimbursement from, or have any recourse against:

- Any UnitedHealthcare Dual Complete® Medicare Advantage plan member who is eligible for both Medicare and Medicaid, for whom the state Medicaid agency is responsible for paying all the member's cost sharing, such as copays, deductibles and coinsurance.
- The member's representative, or the UnitedHealthcare Dual Complete Medicare Advantage organization for Medicare Part A and B cost sharing, such as copays, deductibles and coinsurance, when the state Medicaid agency is responsible for paying these amounts.

Cost Sharing Options

The care provider may either:

1. Accept payment made by or on behalf of UnitedHealthcare Dual Complete® as payment in full; or
2. Bill the appropriate Medicaid state source for the cost sharing amount. A Medicaid ID may be required for Medicaid reimbursement from the state Medicaid agency.

Please refer to the Administrative Guide for more details.

Clinical Program Requirements

Advance Notification

UnitedHealthcare Community Plan

- Advance notification is required for certain planned services listed in the Advance Notification List section of the Administrative Guide.
- Advance notification is required at least 5 calendar days before the planned service date.
- Submitting the request with complete clinical information will help expedite the decision process.
- You can submit advance notification at LINK via the Prior Authorization and Notification application.

To view the most current and complete Advance Notification List including procedure codes and associated services, please visit UHCprovider.com > Menu > Prior Authorization and Notification > Advanced Notification & Plan Requirement Resources > UnitedHealthcare Medicare Prior Authorization Requirements

Prior Authorization/ Notification Requirements

UnitedHealthcare Community Plan

- Prior authorization/Notification is required if a UnitedHealthcare Community Plan member's benefit document requires that services be medically necessary to be covered.
- Notification of a request for service is not a guarantee of payment.
- If prior authorization is required, a clinical coverage review is conducted to determine if the service is medically necessary based on evidence-based clinical guidelines.
- Care providers will be offered a Peer to Peer with the reviewing UnitedHealthcare physician for all prior authorization requests that do not meet medical necessity guidelines

Clinical Coverage Review Process

UnitedHealthcare Community Plan

If insufficient clinical information is submitted, we will send a fax or call the care provider to request additional information.

- If information is provided within the requested timeframe, a clinical coverage review will be conducted to determine medical necessity.
- If additional information is not provided within the requested timeframe, the request for authorization will be denied.

If medical necessity criteria is not meet for a prior authorization or precertification requests:

- A clinical denial will be issued if it is determined that the requested service does not meet medical necessity criteria.
- The member and care provider will receive a denial notice with the option to appeal.

Prior Authorization Resources

UnitedHealthcare Community Plan

- The care provider or facility requesting prior authorization will receive a written decision of clinical coverage determination based on medical necessity.

- View the prior authorization list at UHCprovider.com > Menu > Prior Authorization and Notification > Advanced Notification & Plan Requirement Resources > UnitedHealthcare Medicare Prior Authorization Requirements

- Your primary ways to submit is LINK - Submit prior authorization requests online at Link > Prior Authorization and Notification application.

Prior Authorization Response Times

UnitedHealthcare Community Plan

- Please schedule procedures as far in advance as possible.
- We will provide a decision for standard/non-emergency requests within 14 days of when we receive clinical information.
- Urgent requests will have a decision rendered within 72 hours of receipt of clinical information.
- If we need additional information, response times may vary.

Prior Authorization Contact Information

Phone: 844-368-7150, weekdays, 8 a.m. – 6 p.m.; available 24 hours for emergencies

Web: UHCprovider.com/Link

Radiology & Cardiology Prior Authorization Requirements (EviCore)

UnitedHealthcare Community Plan

- Any advanced imaging/cardiac procedure requiring advance notification will require prior authorization.
- All providers, facilities and other health care professionals are required to obtain authorization **prior** to performing select inpatient, outpatient and office-based procedures.
- Prior authorizations are **not required** for cardiac or radiology procedures **ordered** through an:
  - Emergency room treatment visit
  - Observation unit
  - Urgent care facility
  - Inpatient stay

Exceptions: Electrophysiology implants like pacemakers, which require authorization in an inpatient setting.

Requesting Radiology & Cardiology Prior Authorization

UnitedHealthcare Community Plan

- Initiate authorization online Link > Prior Authorization and Notification application.

Check Prior Authorization Status:

- **Online:** Link > Prior Authorization and Notification application
- **Phone:** EviCore 866-889-8054 - from 7 a.m. to 7 p.m., local time, Monday- Friday

Continuity/Transition of Care Protocol

UnitedHealthcare Community Plan

UnitedHealthcare adheres to two policies related to the Transition and Continuity of Care (TOC/CoC) for its members.

- **Transition of Care (TOC)** allows a “newly” enrolled member (or a member switching to another UnitedHeatlhcare plan) a transition period based on standard TOC/COC requirements **before** he or she is required to transfer from an Out-of-Network (OON) provider to an In-Network (INN) provider in order to receive INN benefits under the terms of the new benefit plan.

- **Continuity of Care (CoC)** allows current members a transition period based on standard TOC/CoC requirements when a participating provider leaves the network.

TOC/CoC Criteria

- **Active Course of Treatment:** involves regular visits with the practitioner to monitor the status of an illness or disorder, provider direct treatment, prescribe medication or other treatment, or modify a treatment.
- **Significant Acute Condition:** A medical condition, more serious in nature, with a sudden onset of symptoms due to injury, illness, or other medical problems that requires prompt medical attention for a limited duration. Examples include pneumonia or cellulitis, acute cholangitis or pancreatitis, heart attack or stroke.
- **Post Partum:** Second Trimester through post-partum - Immediate post partum period is six weeks for vaginal birth and eight weeks for cesarean birth.
- **Serious Chronic Condition:** A medical condition due to disease, illness or other medical problem or disorder that is serious in nature and that continues without cure, or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

TOC and CoC Timeframe

If the right criteria is met, the following timeline will apply:

- **Transition of Care (TOC):** 90 days from member's date of enrollment
- **Continuity of Care (CoC):** 90 days from provider's termination date

- TOC/CoC is limited with an end date.
- When approved, Case Managers and Provider Service Teams will educate the member and care providers about the timelines for TOC/CoC.

Pharmacy Services

Pharmacy

- OptumRx, our pharmacy benefits manager, oversees pharmacy network contracting and claims processing on our behalf.
- Our preferred drug list (PDL) is available at UHCCommunityPlan.com > Health Care Professional > Oklahoma > Dual Complete Program.
  - The drugs listed in the PDL have been reviewed and approved by:
    - The Center for Medicare and Medicaid Services (CMS) for our Medicare Plans.
    - UnitedHealthcare Community Plan Pharmacy and Therapeutics Committee for other Medicaid and commercial products.

Pharmacy Mail Order

Dual Complete members can obtain 90 days supply with one single copay using our mail order pharmacy or a network retail pharmacy provider of their choice.

- Mail order provides home delivery
- 90 days supply reduces the number of visits to the pharmacy

To enroll members in the mail order service:

- **Phone:** 877-889-5802
- **Fax**: 800-791-7997

Prior authorization requests are reviewed and notification is sent back within 24 hours expedited requests and 72 hours standard requests

Pharmacy Prior Authorization

- A 30 day medication supply can be dispensed as an emergency transition supply within the first 90 days of enrollment with the plan.
- Applies when drug therapy must start without delay and prior authorization is not available.
- *This rule applies to Part-D payable non-preferred drugs not included in the PDL and to any drug that is affected by a clinical or prior authorization edit.*

Pharmacy Prior Authorization
Phone: 800-711-4555
Fax: 800-527-0531

Prior authorization requests are reviewed and notification is sent back within 24 hours expedited requests and 72 hours standard requests

DSNP Quality – Medicare Star Ratings

Health Care Quality Measurements

UnitedHealthcare Community Plan

- The Centers for Medicare and Medicaid Services (CMS) has developed a set of Medicare Advantage plan quality measurements called Star Ratings.
- DSNPs are required to adhere to the same set of standards and more due to the population being treated.
- These measurements help guide Medicare beneficiaries to plans that can help them maintain their health and address their customer service needs.
- These measures include:
    - Operational measures such as call center metrics and complaints
    - Healthcare Effectiveness Data and Information Set (HEDIS) measures
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, such as customer satisfaction
    - Pharmacy measures

Star Ratings Initiatives

UnitedHealthcare Community Plan

We are committed to helping our members live healthier lives by addressing their customer service needs.

Current Initiatives to help improve our Star ratings include:

- UnitedHealthcare® HouseCalls Program: Eligible DSNP members are offered an annual home visit from an advanced clinical practitioner who can gather data to help close gaps in care and review medications with the member. This information is shared with the member's primary care physician (PCP).
- Well-care incentives for annual wellness visits, flu shots or completion of health risk assessments.
- Healthcare Quality Patient Assessment Form (HQPAF): Information for PCPs about a member's recent history to help show any gaps in care.

PCP Role in Star Ratings

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- Many of our measures require complete, up-to-date encounter data.
- Some of the measures track the treatment of chronic conditions such as diabetic care, controlling blood pressure and medication adherence.
- Please encourage UnitedHealthcare DSNP members to have an annual physical or well visit to document body mass index (BMI), medications, vital signs and any changes in the patient's health status.

For more information about how our programs can help support your patients who are UnitedHealthcare benefit plan members, please contact your UnitedHealthcare representative.

Doing Business With Us

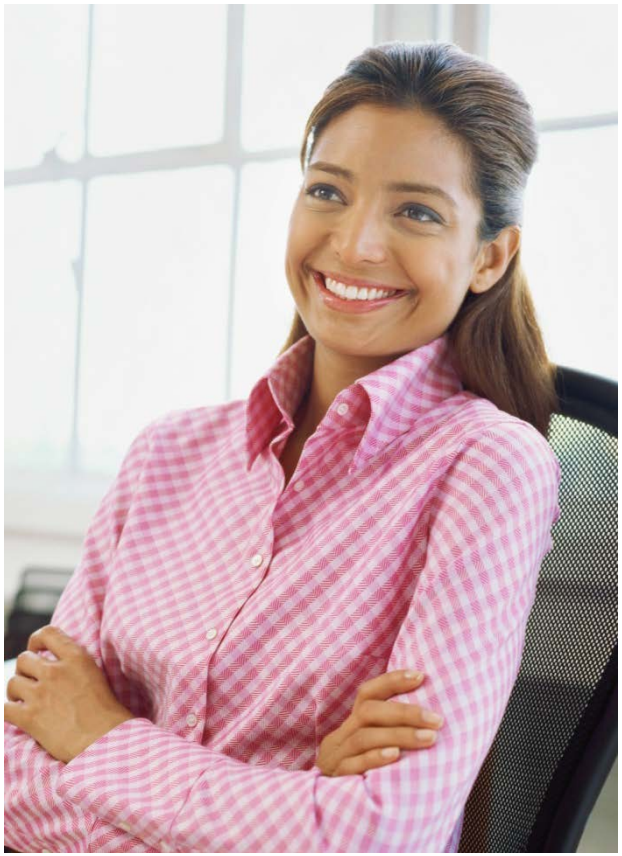
Electronic Claims Submission

UnitedHealthcare Community Plan

For electronic submission, Payer ID 87726 is the most common primary Payer ID. Check with eSolutions and health plan for a different payer ID.

- Link application – claimsLink
- Clearinghouse of your choice: If you receive 835 Electronic Remittance Advice (ERAs) through a vendor, please ask them to enroll you for the 835 through OptumInsight.
- Connectivity Director
- To find out more, please contact your vendor or call Electronic Data Interchange (EDI) at 800-842-1109.

Paper Claims Submission



Mail claims to:

UnitedHealthcare Community Plan
– Oklahoma
PO Box 5270
Kingston, NY 12402-5270

Standard Timely Filing:

- 90 days from the date of service, or the timeframe in your participation agreement

Submitting a Claims Reconsideration

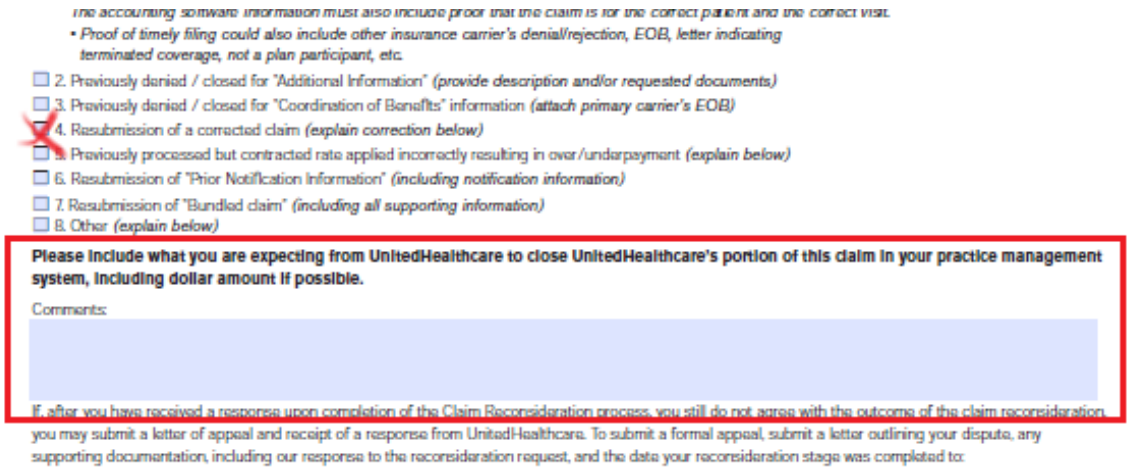
UnitedHealthcare Community Plan

- **Preferred Method:** Please submit claims reconsideration requests electronically through your EDI Clearinghouse or using the claimLink application on Link
- To submit paper claim reconsideration, please use the Claim Reconsideration Request Form for corrections that require specific instructions. The form is not required for basic corrections or adjustments.
- The Claim Reconsideration Request Form is available at UHCprovider.com > Menu > Claims, Billing and Payments > Submit a Claim Reconsideration.

Submitting a Corrected Paper Claim

UnitedHealthcare Community Plan

- On the Claim Reconsideration Form, check the box #4: *Resubmission of a corrected claim*.
- Complete the Comments section, clearly stating what data elements have been corrected and why.



The accounting software information must also include proof that the claim is for the correct patient and the correct visit.
• Proof of timely filing could also include other insurance carrier's denial/rejection, EOB, letter indicating terminated coverage, not a plan participant, etc.

☐ 2. Previously denied / closed for "Additional Information" *(provide description and/or requested documents)*
☐ 3. Previously denied / closed for "Coordination of Benefits" information *(attach primary carrier's EOB)*
☑ 4. Resubmission of a corrected claim *(explain correction below)*
☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment *(explain below)*
☐ 6. Resubmission of "Prior Notification Information" *(including notification information)*
☐ 7. Resubmission of "Bundled claim" *(including all supporting information)*
☐ 8. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare to close UnitedHealthcare's portion of this claim in your practice management system, including dollar amount if possible.

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:

- Send the claim and Claim Reconsideration Request Form to the address on the explanation of benefits (EOB) or back of the member ID card.

Signing Up for Electronic Payments & Statements (EPS)

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With EPS, you receive electronic funds transfers (EFT) for claim payments - and Explanation of Benefits (EOBs) are delivered online.

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your bank account

To receive direct deposit and electronic statements through EPS, please enroll at myservices.optumhealthpaymentservices.com.

Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

Electronic Payments & Statements (EPS)

UnitedHealthcare Community Plan

If you're already signed up for EPS, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan of Oklahoma.

For more information, please call 877-620-6194.

Or go to UnitedHealthcare.com > Quick Links > Electronic Payments and Statements.

Provider Administrative Guide

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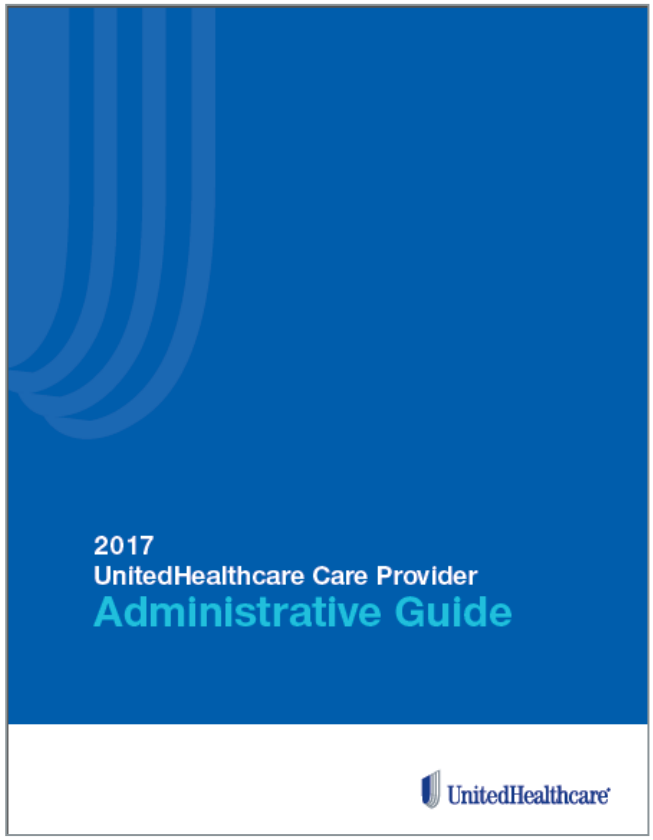
- The Administrative Guide is the same guide you already use for other UnitedHealthcare Medicare Advantage programs.



- Available using the UnitedHealthcare Online LINK application.
- View *Administrative Guide* at UHCprovider.com > Menu > Administrative Guide > 2017 UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage Including UnitedHealthcare West Fee-For-Service.
- Updated April 1 of each year.

Online Provider Resources

UnitedHealthcare Community Plan

Link is your gateway to UnitedHealthcare's online tools.

Use Link applications to help simplify daily administrative tasks:

- Check member eligibility
- Submit a claims reconsideration
- Review coordination of benefits information
- View care opportunities for members

To register for Link, sign in to **UHCprovider.com** using your Optum ID or click "New User" if you do not have an Optum ID.

For more information, click "Link" in "Learn more about Link".

Online Provider Resources

UnitedHealthcare Community Plan

Applications available at Link:

eligibilityLINK Application

- Check member eligibility and review detailed benefits information.
- Can also use the app to find out if referrals, notifications and prior authorizations are required for the member's plan.

claimsLINK Application

- View claim information for multiple UnitedHealthcare plans in a single app
- View letters and remittance advice
- Flag claims for future viewing
- Submit additional information requested on closed or pended claims
- Submit claim reconsideration requests with or without electronic attachments

Online Provider Resources

UnitedHealthcare Community Plan

Applications available at Link:

Care Conductor Application

- Access to:
  - Health Risk Assessments
  - Individual Care Plans

UnitedHealthcareOnline Application

- Resources to help with:
  - Claim submission
  - Advance notification
  - Prior authorization guidelines
  - Member eligibility

UnitedHealthcare Community Plan Application

- UnitedHealthcare Community Plan of Oklahoma program resources:
  - Dual Complete® HMO-SNP information
  - Practice Matters – *Quarterly Newsletters* – ***coming soon***

Reminder: Model of Care Training

UnitedHealthcare Community Plan

The Centers for Medicare & Medicaid Services (CMS) requires all care providers who treat patients in a Special Needs Plan (SNP) to complete annual Model of Care (MOC) training.

- We offer the SNP MOC training annually as a pre-recorded session that takes about 10 minutes to complete.

- For new plans going live **Jan. 1, 2018,** providers will be required to complete the training by **Oct. 1, 2018**. *New 2018 training will be released during Q1 2018.*

UHCprovider.com > Menu > Resource Library > Training

- Scroll to the 2017 Special Needs Plan Model of Care Training
  Registration is required

To learn more, contact **888-878-5499** or **snp_moc_providertraining@uhc.com**.

How We Communicate with You

UnitedHealthcare Community Plan

Administrative Guide:

- Updated annually
- Available using the UnitedHealthcare Online LINK application

Reimbursement Policy Update

- Alerts for any changes in the reimbursement policies or procedures

***Practice Matters* Newsletter:** Published quarterly, *for Community Plan programs*

Network Bulletin Newsletter:

- Announces changes in policies or procedures and updates to the Administrative Guide
- Available using the UnitedHealthcare Online LINK application
- View *Network Bulletin* at UHCprovider.com > Menu > News & Network Bulletin

Oklahoma Physician Advocates

UnitedHealthcare Community Plan

Physician Advocates

Traci Underwood

Starts 8.28

traci_underwood@uhc.com

Laurie Bishop

Starts 9.11

laurie_bishop@uhc.com

Heather Dimartino

860-230-0639

heather_dimartino@uhc.com

Physician Advocates

Anber Noe- Oklahoma City

417-736-9064

anber_t_noe@uhc.com

Provider Relations Service Model

UnitedHealthcare Community Plan

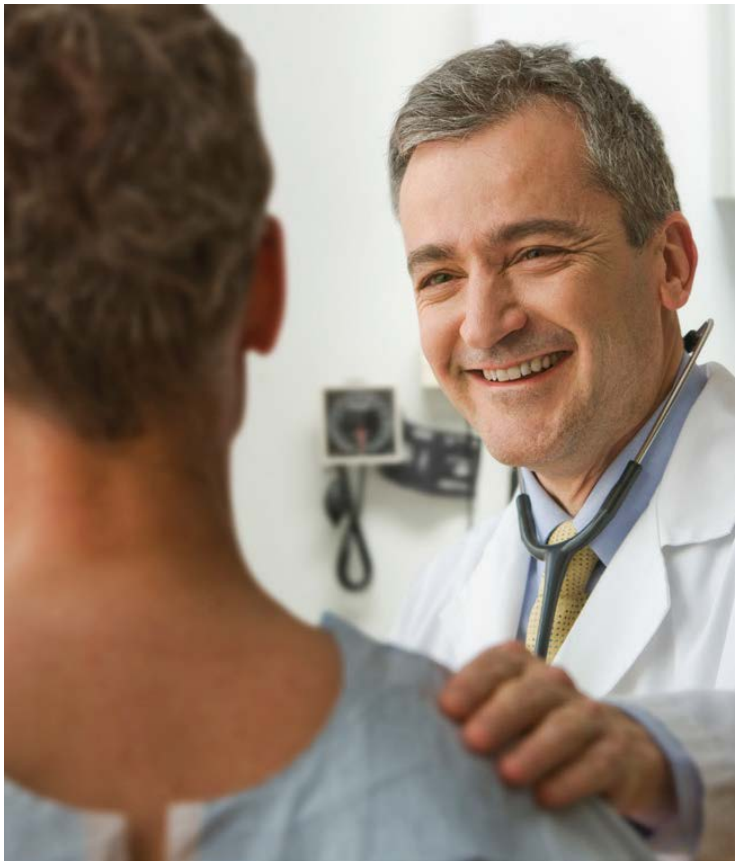
Your Provider Advocate is an important resource when you have questions. They are your single point of contact across all lines of business and benefit plans to help make your interactions with us easier and more efficient.

Please follow the Provider Relations Service Model before contacting a Physician Advocate about claim payment decisions.

1. If you disagree with a claim payment decision, please do one of the following:
   - Use the claimsLink application on Link. To access Link, please sign in to UHCprovider.com.
   - Submit a paper reconsideration – available at UHCprovider.com.
   - Call 844-368-7150.

   Be sure to obtain the 8 or 7 digit code tracking number for future reference.

Provider Relations Service Model (cont'd)



2. If the issue remains unresolved after 30 days, please send your Provider Advocate the member name, member ID number, date of service and tracking number or a copy of the claim.
3. Your Provider Advocate will work with Market Service Agents and others to determine the cause and resolve your issue.

Additional Provider Resources & Key Phone Numbers

UnitedHealthcare Community Plan

- **UnitedHealthcare Dual Complete®** Medicare Advantage Quick Reference Guide
- **UnitedHealthcare Dual Complete®** Medicare Advantage Frequently Asked Questions
- Understanding **UnitedHealthcare Dual Complete®,** a Medicare Advantage plan
- UnitedHealthcare Medicare Solutions and UnitedHealthcare Community Plan – Medicare Prior Authorization Requirements

Behavioral Health
Phone: 844-368-7150
Hours: Monday – Friday, 8 a.m. to 6 p.m. local time

Dental: UnitedHealthcare Dental
Phone: 844-368-7150
Hours: Monday – Friday, 8 a.m. to 6 p.m. local time

Vision: March Vision
Phone: 844-796-2724
Hours: Monday – Friday, 8 a.m. to 5 p.m

Non-Emergent Transportation: LogistiCare
Phone: 866-418-9812
Hours: Monday – Friday, 8 a.m. to 5 p.m. local time
Online: Logisticare.com

OptumHealth NurseLine
Phone: 877-440-9407
Hours: 7 days a week, 24 hours a day

Thank you

UnitedHealthcare®
Community Plan