UnitedHealthcare Compass for Health Insurance Exchanges
UnitedHealthcare Compass

- **Health Insurance Marketplaces**, also known as **Exchanges**, are intended to help individuals and small businesses research, compare and enroll in qualified health plans from health insurers based on quality, provider network, benefits and cost.

- UnitedHealthcare **Compass** is specifically designed for Individual Exchanges
  - Primary care focus
  - Referrals to network specialists
  - Customized network of care providers
  - Efficient and affordable care

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**Additional Resources:**
- HealthCare.gov
- Medicaid.gov
- Medicare.gov
- UHC.com/reform
- Healthcarelane.com
UnitedHealthcare Compass benefit plans cover Essential Health Benefits.*

- Preventive and wellness services and chronic disease management
- Laboratory services
- Pediatric services, including oral and vision care
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Rehabilitative and habilitative services and devices
- Prescription drugs
- Mental health and substance use disorder services

* Large groups and grandfathered plans are not required to cover Essential Health Benefits.
* Some plans may impose non-monetary limits, such as the number of physician visits, days in the hospital, and prescription drug refills.
* Care providers must be contracted with Eyecare Networks for routine vision care. To request network participation, please visit Spectera.com/providers or call 800-638-3120.

Essential information
- State definitions will vary
- No lifetime limits
- No annual dollar limits
- 100 percent coverage for preventive and wellness services
- New out-of-pocket maximum accumulation rules and deductible ceilings
Metallic Coverage Levels

While the scope of benefits are the same for Compass benefit plans, the average cost share of those benefits will vary.*

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Cost per visit/prescription</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Plan pays</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Member pays</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
</tr>
</tbody>
</table>

* All Qualified Health Plans must offer at least one silver and one gold plan
* For Individual Exchange, member responsibility will vary based on Federal subsidies provided towards reduced cost share
Compass Benefit Plan Design

Affordable Solutions for Individual Exchange Members

• UnitedHealthcare Compass benefit plans offer in-network coverage only, except for emergency care services.

• Cost share amounts will vary based on eligibility for cost share reductions.

<table>
<thead>
<tr>
<th>Plan type</th>
<th>Traditional</th>
<th>Copay</th>
<th>HSA</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bronze Compass 4200</td>
<td>Silver Compass 5400</td>
<td>Silver Compass 6500</td>
<td>Silver Compass 7600</td>
</tr>
<tr>
<td>Deductible and Coinsurance</td>
<td>You pay:</td>
<td>$4,200</td>
<td>$5,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Deductible (Family)</td>
<td>You pay:</td>
<td>$8,400</td>
<td>$10,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You pay:</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Out-of-pocket Maximum (Medical and Pharmacy Combined)</td>
<td>Individual</td>
<td>You pay:</td>
<td>$6,600</td>
<td>$5,500</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>You pay:</td>
<td>$19,200</td>
<td>$19,200</td>
</tr>
</tbody>
</table>

Medical

Primary Care Physician (PCP) You pay: 30% after deductible $25 copay $20 copay $40 copay $10 copay $20 copay $15 copay 40% after deductible 10% after deductible $40 copay

Preventive Care You pay: No charge - 100% covered in network $0

Specialist You pay: 30% after deductible $40 copay $40 copay $60 copay $40 copay $50 copay $30 copay 40% after deductible 10% after deductible No charge after deductible

Urgent Care Visit You pay: 30% after deductible $75 copay $60 copay $100 copay $60 copay 20% after deductible $75 copay 40% after deductible 10% after deductible No charge after deductible

Emergency Room Fees You pay: 30% after deductible 20% after deductible 25% after deductible 10% after deductible 30% after deductible $150 copay 40% after deductible 10% after deductible No charge after deductible

Outpatient Surgery You pay: 30% after deductible 20% after deductible 10% after deductible 20% after deductible 10% after deductible 20% after deductible 10% after deductible 40% after deductible 10% after deductible No charge after deductible

Lab and X-ray You pay: 30% after deductible 20% after deductible 10% after deductible 20% after deductible 10% after deductible 20% after deductible 10% after deductible 40% after deductible 10% after deductible No charge after deductible

Hospital Stay You pay: 30% after deductible 20% after deductible 10% after deductible 25% after deductible 10% after deductible 20% after deductible 10% after deductible 40% after deductible 10% after deductible No charge after deductible

Maternity Stay You pay: 30% after deductible 20% after deductible 10% after deductible 25% after deductible 10% after deductible 20% after deductible 10% after deductible 40% after deductible 10% after deductible No charge after deductible

This sample of plan options is for informational purposes only. Refer to the member’s Summary of Benefits for benefit plan details.
Member ID Cards

1. Individual Exchange benefit plans identifier located in the “Customer Name Field”

2. Payer ID used for electronic data interchange

3. Primary Care Physician name and phone number

4. Name of the member’s benefit plan

5. Member ID card reference to identify benefit plans that are subject to additional care provider manuals or supplements

6. Referral requirement reminder

7. The W500 identifies members with the Additional Network Benefit

This sample ID card is for illustration only. Actual information varies depending on payer, plan and other requirements.
Compass Network Service Area

**UnitedHealthcare Compass**

- Customized network designed for Compass benefit plans
- Network offered in certain counties for participating states where we act as a Qualified Health Plan issuer
- Networks offer access to many quality care providers¹
- For the complete list of the Compass network service area counties by state go to [UnitedHealthcareOnline.com > Tools & Resources > Products and Services > UnitedHealthcare Compass.](#)

¹ Standard policies and procedures must be followed for referrals and notifications.
Patient Eligibility

Check the following items when checking eligibility at the point of service:

- Verify your participation status for the member’s benefit plan on Optum Cloud.
- Confirm a referral is on file at UnitedHealthcareOnline.com to help ensure your patients receive in-network benefits.
- Know if your patients are current with their premium payments to understand potential financial liability.
Three-Month Grace Period

What is the three-month grace period?

Health plans are required to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Exchange.

The grace period applies to those who receive Federal subsidy assistance in the form of an advanced premium tax credit, and who have paid at least one full month’s premium within the benefit year.

How it Works

Month 1:
Claims are paid.

Month 2:
Claims are pended and letter sent to care provider with a copy to the member.**

Month 3:
Member coverage is retroactively terminated as of the end of the first month of the grace period; the last two months of claims are denied for no member benefit coverage.

**Some state regulations may require payment during the grace period.
Three-Month Grace Period - Texas

What is the three-month grace period?

Health plans are required to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Exchange.

The grace period applies to those who receive Federal subsidy assistance in the form of an advanced premium tax credit, and who have paid at least one full month’s premium within the benefit year.

How it Works

Months 1, 2 & 3:
Claims are paid throughout three-month grace period.

After Month 3:
Following the last month of the grace period, if a member has an outstanding premium, the member’s health plan is retroactively terminated.

Balances are recouped from the care provider, and the care provider seeks reimbursement directly from the member for services rendered.
Primary Care Physician (PCP)

PCP Selection

- Every member must select a PCP.
- Each family member may select a different PCP.
- PCP must be located close to where the subscriber lives or works.
- If a member does not select a PCP then UnitedHealthcare will assign one.

PCPs may generate a membership roster report by using the self service reporting tool available at UnitedHealthcareOnline.com.

Care providers must maintain the same status for accepting patients across all health plans and health insurers.
Referral Requirements

Routine Referrals
• PCP or covering physician with same tax ID number (TIN) must submit electronic referral
• Six visits allowed per referral
• Valid up to six visits or six months, whichever comes first
• Any claim from a specialist TIN is subtracted from number of visits within the same date range

Standing Referrals
• For long-term treatment of chronic conditions
• 99 visits allowed per referral
• Valid up to 99 visits or six months, whichever comes first
• PCP can issue additional referrals after visits are used or referral expires

PCP issues electronic referrals to each network specialist.
Referral Requirements (cont’d)

Eligible Services NOT Requiring a Referral

• Network Obstetrician/Gynecologist
• Routine refractive eye exam from a network provider\(^1\)
• Mental health/substance use disorder services with network behavioral health clinicians
• Services from physicians in the same TIN as the member’s PCP
• Services from a pathologist, radiologist or anesthesiologist
• Services rendered in any emergency room or network urgent care center or convenience clinic
• Physician services for emergency/unscheduled admissions\(^2\)
• Any services from inpatient consulting physicians

\(^1\) One exam every two years is a standard benefit in fully insured medical coverage.
\(^2\) Unscheduled admissions require standard notification after the patient is admitted, as described in the Administrative Guide.
Referral Requirements (cont’d)

• Any non-physician type services:
  • Outpatient lab, x-ray, or diagnostics
  • Physical therapy, durable medical equipment, home health, prosthetic devices or hearing aids
  • Rehabilitation services, with the exception of manipulative treatment and vision therapy performed by a physician

Referrals are required to see network specialists.

1 One exam every two years is a standard benefit in fully insured medical coverage.
2 Unscheduled admissions require standard notification after the patient is admitted, as described in the Administrative Guide.
Referral Submission

Referral Submissions

- Available 24 hours a day, 7 days a week
- Effective immediately
- Viewable online within 48 hours
- User profiles must have permission assigned to access the referral screen

Referral Status and Submission Online Tutorial available under Help.

⚠️ Please contact your administrator if you do not have access to referral status or submission functions. The administrator should consult the User ID & Password Management Quick Reference Guides under Help to change security levels for user profiles.
Non-network care providers

What is the W500 Additional Network Benefit?

• Compass benefit plans include W500 Additional Network Benefits for certain services to be provided by an additional network of providers.

• W500 benefits cover urgent services, emergency services and related admissions and pre-approved services for gap exceptions.

If services are not available by an in-network care provider:

• The member’s PCP reviews the W500 provider directory to find a physician.

• If a specialist is found, then the member’s PCP may submit a request to UnitedHealthcare to seek approval for the member to see the physician participating for the W500 benefit plan at the in-network benefit level.

• If a specialist participating for the W500 Additional Network Benefit plan is not found, then the member’s PCP may submit a request to seek approval for the member to see a non-network physician at the in-network benefit level.
Prior Authorizations and Notifications

Compass requires prior authorization for certain planned services for medical necessity determination. The list of services and the process for prior authorizations is the same one outlined in the Administrative Guide, to include cardiology and radiology notifications.

- Protocols related to inpatient admission notification remain the same and continue to be the responsibility of the hospital.
- Services that require prior authorization and notification may also require a referral to the specialist performing the service.
- The responsibility for obtaining prior authorization resides with the ordering/rendering physician whether it be the PCP or a Specialist with an active referral.
Additional Resources

Find UnitedHealthcare Compass benefit plan information at:
UnitedHealthcareOnline.com > Tools & Resources > Products and Services > UnitedHealthcare Compass.
Thank you!