

# UnitedHealthcare Certificate of Coverage 2007 to 2011 Comparison

Texas



UnitedHealthcare is introducing a new Certificate of Coverage (COC) in 2011. The 2011 COC provides an opportunity to enhance patient outcomes and reduce health care cost. Some of the key changes in the 2011 COC include:

- ▶ Medical necessity
- ▶ Prior authorization
- ▶ Eligible Expense for Non-Network Facility-Based Physicians
- ▶ Benefit updates to four benefit categories
- ▶ Pharmacy – Prior authorization

### Medical Necessity

Simply put, medical necessity helps establish a quality patient care program where members and their physicians work together to combine cost-effective procedures with evidence-based treatments – all while staying within benefit plan requirements.

### Prior Authorization

Prior authorization is a core component of medical necessity. It involves conducting pre-service reviews to determine whether the proposed service meets the clinical requirements for medical necessity, appropriateness, level of care and effectiveness, as defined by nationally recognized clinical guidelines. The 2011 COC reflects the change from pre-service notification in the 2007 COC to prior authorization.

### Eligible expense for non-network facility-based radiologists, anesthesiologists, pathologists and emergency care physicians

(Applicable to the following products:

Choice Plus)

UnitedHealthcare is applying non-network reimbursement schedules to:

- ▶ Non-emergency inpatient or outpatient covered health services delivered by non-network emergency care physicians, anesthesiologists, radiologists and pathologists in a network facility, including Ambulatory Surgery Centers (ASCs).

- ▶ Emergency inpatient or outpatient covered health services delivered by non-network emergency care physicians, anesthesiologists, radiologists and pathologists in either a network or non-network facility, including hospital and freestanding emergency rooms.

Members can visit the Find Physicians & Facilities section of the myuhc.com® member website to determine the network status of facility-based specialties of anesthesiology, radiology, pathology and emergency medicine.

### Pharmacy

#### Prior Authorization

To obtain coverage for certain medications, the member requirement is changing from pre-service notification to prior authorization.

#### Retail Before Mail

When a member is new to a drug therapy, they may be required to obtain two (2) fills at retail before obtaining a 90-day fill through mail order.

### Medical benefit coverage overview for brokers and customers

The following overview provides a high-level comparison, by benefit category, of the 2007 COC to the 2011 COC. The benefit information provided represents UnitedHealthcare national standards. State specific regulations will always override these standards, and some State specific benefit plans may vary from these national standards.

## UnitedHealthcare Certificate of Coverage 2007 to 2011 Comparison

### New Benefit Standards for 2011 Certificate of Coverage

Topic	2007 COC	2011 COC
Pre-Service Benefit Reviews	<ul style="list-style-type: none"> <li>• Pre-service notification required for services as listed in the 2007 COC</li> <li>• Review of services to determine eligibility and benefit exclusions</li> </ul>	<ul style="list-style-type: none"> <li>• Prior authorization required for medical and pharmacy services as listed in the 2011 COC</li> <li>• Review of services to determine eligibility, benefit exclusions and medical necessity</li> <li>• Services determined to be not medically necessary do not meet the criteria of a Covered Health Service and are therefore excluded benefits</li> </ul>
Eligible Expense for Non-Network Facility-Based Radiologists, Anesthesiologists, Pathologists and Emergency Care Physicians who provide: <ul style="list-style-type: none"> <li>• Non-emergency inpatient or outpatient covered health services in a network facility, including Ambulatory Surgery Centers (ASCs)</li> <li>• Emergency inpatient or outpatient covered health services in either a network or non-network facility, including hospital and freestanding emergency rooms</li> </ul>	Services covered at the network benefit level of deductible, coinsurance, and/or copay applied against the amount payable under the plan, which is generally determined based on billed charges.	Services covered at the network benefit level of deductible, coinsurance and/or copay with the amount payable under the plan determined as follows: <ul style="list-style-type: none"> <li>• For emergency services: the amount payable will be based on the highest of the median network contracted rate, the non-network rate, or the amount payable under the Medicare program (not to exceed the provider's billed charges)</li> <li>• For non-emergency services: the amount payable will be based primarily on a percentage of published rates allowed by the Medicare program</li> </ul>
<b>Benefits Changed from 2007 to 2011 Certificate of Coverage – Categories in Alphabetical Order as found in the Schedule of Benefits</b>		
Durable Medical Equipment (DME)	Benefit standard of \$2,500 annual limit combined network/non-network, includes wound vacuums <sup>1</sup>	Wound vacuums are not subject to the standard \$2,500 annual DME dollar limit <sup>1</sup>
Physicians Office Services - Sickness and Injury	No member pre-service notification requirement	New requirement for members to obtain prior authorization for non-network BRCA (breast cancer susceptibility) genetic testing
Rehabilitation Services, Outpatient Therapy and Manipulative Treatment	Utilizes term "Chiropractic"	Changed term from "Chiropractic" to "Manipulative Treatment"
Surgery - Outpatient	No member pre-service notification requirement	New requirement for members to obtain prior authorization for non-network diagnostic cardiac catheterization, electrophysiology implant, and sleep apnea surgeries
Therapeutics Treatments - Outpatient	Member pre-service notification requirement for non-network dialysis	Additional requirement for members to obtain prior authorization for non-network intensity modulated radiation therapy and MR-guided focused ultrasound

<sup>1</sup> The annual DME limit of \$2,500 does not apply to any DME that is rehabilitative/habilitative in nature and thus is an Essential Health Benefit under the Patient Protection and Affordable Care Act.

### Benefits NOT Changed – Product Standards are generally the same for both 2007 and 2011 Certificate of Coverage

- Ambulance
- Clinical Trials
- Congenital Heart Disease Surgeries
- Dental - Accident Only
- Dependent Age
- Diabetes Services
- Emergency Health Services
- Hearing Aids
- Home Health Care
- Hospice
- Hospital - Inpatient Stay
- Lab, X-ray and Diagnostics - Outpatient
- Lab, X-ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine
- Dollar limits no longer apply for essential benefits
- Mental Health Services
- Member Requirements for Non-Network Services
- Neurobiological Disorders - Autism Spectrum Disorder Services
- Ostomy Supplies
- Pharmaceutical Products - Outpatient
- Physician Fees for Surgical and Medical Services
- Physician's Office Services - Sickness and Injury
- Pre-existing condition exclusion
- Pregnancy
- Preventive Care Services
- Prosthetic Devices
- Reconstructive Procedures
- Scopic Procedures - Outpatient
- Skilled Nursing Facility
- Substance Use Disorder Services
- Transplantation Services
- Urgent Care
- Vision Exam

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Insurance Company



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