# Information About Your Oxford Coverage

## Overview of provider reimbursement methodologies

Generally, we pay participating providers ("network providers") on a fee-for-service basis. Fee-for-service based payment schedules differ depending on the type of provider, geographic location or site of service, and may include payment based on each office visit, a hospital day, procedure or service performed, item furnished, course of treatment, or other units of service. A unit of service, such as a hospital day, may include more than a single procedure or item. We may also limit the number of services or procedures that we will pay for during any single office visit or for any single procedure; or for multiple procedures performed at the same time. This practice is known as “bundling” and is used by many third party payers, including the Medicare program. Some providers have agreed to accept variable fee-for-service payments (payment based on a mutually agreed upon budget) so long as they receive at least a minimum fee. We may make modifications to our fee-for-service compensation mechanism during the term of your coverage.

We do not typically “withhold” a portion of a physician’s contracted fees, which might be paid later depending on the physician’s performance or our financial performance. (The amount retained is called a “withhold.”) However, withholds are among the sanctions that we may implement with respect to physicians who have a demonstrated practice of not following our policies, for example, by improper billing practices, consistently referring members to providers who are not network providers, or by failing to obtain required referrals or precertifications (sometimes referred to as preauthorizations). We may profile network providers’ billing, referral, utilization or other practices, and develop other financial disincentives for providers who do not follow our policies and procedures during the term of your coverage.

We do not generally provide bonuses or other incentives to network providers. However, we have entered into incentive agreements with a few “intermediaries,” such as provider groups and independent practice associations (IPAs). Incentive agreements may be based on referrals to specialists or hospitals and other facilities, economic factors, quality factors, member satisfaction factors, or a combination of these and other factors. Incentive agreements typically, but not always, require the group to meet mutually agreed upon quality measures as a condition of obtaining a bonus based on cost or utilization. Financial incentives or disincentives may also be adopted to promote electronic billing practices or other e-commerce initiatives, or to promote compliance with our utilization management policies. In addition, physicians may be paid at higher rates for certain surgical procedures, if they perform the surgery in their offices, or at ambulatory surgical centers. We may enter into additional incentive agreements with providers during the term of your coverage. Network providers who contract through intermediaries that contract may be subject to incentives. Our contracts with intermediaries typically, but not always, limit the nature and scope of the incentives the group may enter into with network providers.

We do not pay individual network physicians or practitioners on a capitated basis. However, as described above, we have negotiated a few capitation agreements with IPAs. We may enter into additional capitation agreements during the term of your coverage or terminate existing capitation agreements.

Individual practitioners who are paid from funds available under capitated agreements with IPAs are generally paid on a fee-for-service basis, but some IPAs may pay individual primary care physicians (PCPs) on a capitated basis. In addition, practitioners contracting through IPAs may be subject to incentive agreements. IPAs with which we contract may enter into capitation agreements with network physicians. Intermediaries with which we contract might enter into

or terminate capitation agreements or incentive agreements with network physicians, facilities or practitioners during the term of your coverage. We may audit network providers' billing patterns or, licensing compliance, or require documentation that services billed were provided. If the provider cannot demonstrate that services have been provided, or that the services billed are medically necessary and consistent with the services provided, we may seek to recover funds paid to the provider, reduce future payments to the provider, or take other action, such as implement a fee reduction or withhold until the provider has corrected their behavior. A brief description of the compensation mechanisms applicable to different providers is set forth below.

**Network physicians** - The compensation mechanisms used for network physicians are described in the overview above. A large majority of our network physicians are reimbursed by us or an intermediary on a discounted "fee-for-service" basis. Some network physicians have contracted with IPAs or are aligned with other network physicians that either: 1) accept compensation based upon a predetermined budget for the cost of covered services to members, or 2) are subject to an incentive agreement (bonus) based on quality and utilization measurements. In addition, some physician groups are eligible to be paid a bonus based either on the total cost incurred by us for covered services rendered to members who select or are assigned to a member of the physician group as their PCP, or other utilization measures, such as the total number of days these members (in the aggregate) spend in the hospital or percentage of referrals to certain specialists, hospitals or other facilities.

**Limited license practitioners** - We reimburse limited license practitioners (non-physician health care professionals) on a fee-for-service basis. We have contracted with a company to manage our physical therapy benefit and certain other therapy benefits. We have also contracted with a company to manage our chiropractic benefit. We may enter into additional capitation and/or incentive agreements with other limited license practitioners during the term of your coverage.

**Laboratory services** - We have contracted with laboratories who have agreed to be paid on a fee-for-service basis, with total fees limited based on a mutually agreed budget for laboratory services. The company may have a financial incentive to contain the annual aggregate cost of imaging services. We have other network labs that are paid through fee-for-service arrangements.

**Pharmacy** - We have entered into an arrangement with a national pharmacy benefit management company that, in turn, contracts with pharmacies to provide pharmacy products and services to members. The pharmacies are paid for the prescription drug products they dispense to members and they receive a fee for dispensing the prescriptions. The pharmacy benefit management company also provides certain administrative services in connection with administration of Oxford plan pharmacy benefits. We may contract with pharmacies known as "specialty" pharmacies to provide certain pharmaceuticals, such as infertility drugs.

**Hospital and other ancillary facilities** - Reimbursement to network facilities is made on a fee-for-service basis. For inpatient services, payment is generally on the basis of a "per day" rate, or on a case rate for an entire stay based on the diagnosis. In general, we negotiate agreements with individual hospitals or hospital systems. We do not have capitation agreements with any of our network facilities. However, we have entered into an incentive arrangement with an IPA for medical management of subacute facilities. The IPA pays contracting sub-acute facilities on a fee-for-service basis. Certain hospitals are developing their own programs to reduce unnecessary hospital inpatient stays and lengths of stays. We may enter into capitation and/or incentive agreements with hospitals or physicians during the term of your coverage.

**Radiology services** - We have, through an intermediary, contracted with radiologists who have agreed to be paid on a fee-for-service basis. The company may have a financial incentive to contain the annual aggregate cost of imaging services.

**Nonparticipating (out-of-network) providers** - Providers that have not entered into contracts with us (directly or indirectly through groups), including providers in the Oxford service area* and providers outside the Oxford service area, are paid on a fee-for-service basis. Out-of-network providers are paid based on our determination, using various industry standards. Such standards may include lesser of Medicare, databases of competitive fees, or another standard as provided in your Certificate of Coverage and Summary of Benefits. We may seek to impose bundling rules or other limitations on bills received from out-of-network providers. If you received in-network benefits from an out-of-network provider and are billed by the out-of-network provider, please contact us. We may audit out-of-network providers' billing patterns, licensing compliance, or require documentation that services billed were provided and that the services provided were medically necessary. Any or all of these audits may result in nonpayment to the provider for these unusual or fraudulent practices. In some circumstances, this may result in balance billing to the member. If that occurs, please contact us.

**Effect of Reimbursement Policies** - We believe that the implementation of these reimbursement methodologies has produced the results they were designed to accomplish (i.e., access to high quality providers in our service area, and cost-effective delivery of care). Through the application of our quality assurance protocols, we continuously monitor our providers to ensure that our members have access to the high standards of care to which they are entitled. If a particular reimbursement policy affects a physician's referral to a particular out-of- network provider, our members have the right to request a referral to a different out-of-network provider.

**Definitions** - In addition to the definitions in your Certificate, Contract or Handbook (whichever is applicable), key words in this section have the following meaning:

**Bonus:** An incentive payment that is paid to physicians who have met all contractual requirements to obtain the bonus.

**Capitation, Capitated:** An agreed-upon amount, usually a fixed dollar amount or a percentage of premium, that is paid to or budgeted for the provider or IPA regardless of the amount of services supplied. Capitation formulas may include adjustments for benefits, age, sex and other negotiated factors. Usually, the capitation amounts are paid or allocated on a monthly basis.

**Incentive agreements:** In general, "withholds" and "bonuses" are known as "incentive agreements." Incentive agreements may also include higher than standard fees or penalties for failure to adhere to our policies, such as making referrals only to network providers when network providers are capable and available to provide necessary services to members, or based on the provision of services at specific sites of service. Under such agreements, providers are paid less (some portion of their fee is reduced or withheld) or paid more (such as in the form of a bonus) based on one or more factors that may include (but are not limited to): member satisfaction, quality of care, compliance with our policies, control of costs, and their use of services.

*The Oxford service area includes Connecticut, New Jersey and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau and Suffolk).

**IPA:** An IPA (independent practice association) is an organization that contracts with physicians and other health care providers.

**Us, We, Our:** When coverage is provided under Oxford HMO, it means Oxford Health Plans (NJ), Inc. or Oxford Health Plans (CT), Inc. When coverage is provided under Oxford insurance company, it means Oxford Health Insurance, Inc. In addition, it can also include third parties to whom we delegate responsibility for providing administrative services relating to coverage, such as utilization management.

**Withhold:** Percentage of a physician's fee that is held back or reserved as an incentive to encourage appropriate and efficient medical treatment or billing.

## State-Specific Notices

The following pages include state-specific notices for members of those plans. Information in these notices is current as of the date of issue and may be subject to change at any time due to employer-directed plan changes, state mandates and federal laws. Please refer to your Certificate of Coverage (COC) or Summary Plan Description (SPD) for specific information on your benefits or refer to your member website for the most up-to-date information.

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## Connecticut

### Important Information for Connecticut Plan Subscribers

### Health Care Services from Out-of-Network Providers

### For plans that contain Network and Out-of-Network benefits:

You may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network providers if (i) you are diagnosed with a condition or disease that requires specialty care and we do not have a Network provider with the required specialty training within our Network; or (ii) a participating provider is not available to provide the covered benefit without unreasonable travel or delay. In this situation, you may contact us at the telephone number on your ID card, or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider. If your care is coordinated through an Out-of-Network provider, Covered Health Care Services will be paid as Network Benefits, and you will only be responsible for your in-network cost sharing amount.

#### For plans that only contain Network benefits:

You may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network providers if (i) you are diagnosed with a condition or disease that requires specialty care and we do not have a Network provider with the required specialty training within our Network; or (ii) a participating provider is not available to provide the covered benefit without unreasonable travel or delay. In this situation, you may contact us at the telephone number on your ID card or your Network provider can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network provider to coordinate care through an Out-of-Network provider, and you will only be responsible for your in-network cost sharing amount.

### Prescription Drugs from Out-of-Network Providers

As part of your health benefits, you may be eligible to receive credit toward your in-network annual coinsurance, copayment, deductible, or other out-of-pocket expenses when you purchase a prescription drug from an out-of-network provider at a lower cost than the average amount paid by your health carrier to in-network providers for the same drug.

To receive this credit, you must submit proof of payment for the out-of-network prescription drug purchase.

How to Submit Proof of Payment:

1. Electronically

   Access the online proof of payment form: Visit https://www.optumrx.com/forms.html and locate the reimbursement form under "File for a hassle-free claim reimbursement online" Click "File a form online", include all required documentation requested on the form, and submit.

2. By Mail

   Access the printable proof of payment form: Visit https://www.optumrx.com/content/dam/optumrx-o5/PRR%20form_OTC%20Contraceptives_508.pdf, include all required documentation requested on the form, and mail to the address listed on the form under "Instructions for submitting form."

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## New Jersey

### Important Information for Subscribers of Oxford Health Plans (NJ), Inc.

### Independent Consumer Satisfaction Survey results

If you are a New Jersey member and would like to request the New Jersey Independent Consumer Satisfaction Survey results and an analysis of quality outcomes of health care services of managed care plans in the State, contact the Office of Health Care Quality Assessment at:

New Jersey Department of Health
P.O. Box 360
Trenton, NJ 08625-0360
or 609-984-7334.

#### Managed Health Care Consumer Assistance Program

This program was created as a means to assist consumers in better understanding the current status of the health insurance market and particularly managed care. The toll-free phone number for the Managed Health Care Consumer Assistance Program is 1-800-446-7467.

### Organ Donation

Organ, eye and tissue donation gives people a second chance at life. To learn more about the benefits of organ and tissue donation and transplantation, or register to be a donor, visit https://www.njsharingnetwork.org/.

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## New York

### Important notice to New York Subscribers of Oxford Health Insurance, Inc. & Oxford Health Plans LLC

New York law requires notice of certain mandatory benefits provided by your contract with UnitedHealthcare. If your employer has more than 100 employees, your coverage must include the following:

- Colorectal cancer preventive screenings*
- All additional colorectal cancer examinations and laboratory tests*

*As recommended in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals. The most recently published guidelines of the American Cancer Society can be found on their website, cancer.org.
Please refer to your Certificate of Coverage for specific information on your covered benefits. Benefits may require pre-authorization or may be subject to other conditions or limitations as allowed by state law.

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## Rhode Island

### Important Information for Subscribers of Oxford Plans who Reside in Rhode Island

### Rhode Island All-Payer Claims Database Member Opt-Out Notification

State law requires health insurers and administrators in Rhode Island to submit certain information about plan enrollees to the Rhode Island All-Payer Claims Database (RI APCD). Information we submit includes your eligibility details and medical and pharmacy claims data. Personal information such as names or any other information that could be used to identify you will not be provided to the State of Rhode Island, but will be provided to a separate database that is required to keep personal information secure.

Even though your information will be kept anonymous, you have the option to not participate in the RI APCD program. If you do not want your eligibility, medical and pharmacy claims data shared with RI Department of Health (DOH), you may opt-out at any time.

To opt-out, visit the RI APCD Opt-Out website at riapcd-optout.com, or call the Rhode Island Health Insurance Consumer Support Line (RI-REACH) toll-free at 1-855-747-3224 to ask questions about the opt-out process. We will be contacted by the RI DOH to confirm your exclusion from our RI APCD data submission.

You may register opt-out preferences on behalf of any minors covered under your plan. Each adult individual in your family who chooses not to participate in the RI APCD will need to opt out separately.

Visit www.health.ri.gov/healthcare/about/quality/ for more information, or email questions to OHIC.RIAPCD@ohic.ri.gov.

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## Vermont

### Important Information for Subscribers of Oxford Plans who Reside in Vermont

Your policy or certificate is not subject to regulation by Vermont.