

2018 COPAYMENT GUIDELINES FOR NORTHWEST (OREGON & WASHINGTON)

BENEFIT CONSIDERATIONS

Copayments vary depending on the member's coverage plan. Refer to the UnitedHealthcare West SignatureValue member Plan Code Data or member specific benefit plan document [e.g., Evidence of Coverage (EOC) and Schedule of Benefits (SOB)] or contact UnitedHealthcare's Customer Service department at 1-800-624-8822 for copayment information for specific coverage plans, in addition to using these guidelines.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COPAYMENT GUIDELINES

Benefit	Copayment Guidelines
Allergy Testing and Treatment	Refer to the member SOB to determine if the plan has a copayment for allergy testing/treatment. For coverage of allergy serum a copayment may or may not apply. Refer to the member SOB.
Ambulance Transportation	For members with a copayment for Ambulance Transportation the following guidelines apply: <ul style="list-style-type: none"> For urgent/emergent ambulance transportation, the member is to pay one copayment per trip. A leg is equivalent to a trip (e.g., from Point A to Point B). For Non-Urgent/Non-Emergent ambulance transportation, the member is to pay one copayment per roundtrip when the transport from one facility to another is authorized by UnitedHealthcare or the Medical Group/IPA. Note: An additional Ambulance Transportation copayment does not apply when the trip is a transfer to another facility directed by the member's Medical Group/IPA or UnitedHealthcare.
Breast Pumps	Refer to the Medical Management Guideline titled <i>Preventive Care Services</i> for specific information on services that may fall under preventive care due to the expanded women's preventive health mandate.
Dental Anesthesia and Oral Surgery	The copayment policy for oral surgery and dental anesthesia is as follows: <ul style="list-style-type: none"> The copayment should be collected per oral surgery procedure, including TMJ surgery. An outpatient surgery or hospital inpatient copayment may be applicable in addition to the dental anesthesia copayment. Note: In instances where the contracted rate of the payer with financial responsibility is less than the member's copayment, the member will pay only the amount of the contracted rate.
Dialysis	<ul style="list-style-type: none"> For dialysis performed in a dialysis center/facility, a copayment may be required. A separate copayment is not assessed for medications (e.g., Epoetin) administered in the dialysis facility. For dialysis (peritoneal or hemodialysis) in member's home, only the home health copayment may apply, if any.

Benefit	Copayment Guidelines
Diabetic Supplies and Equipment	<p>If the item requested would be considered DME, as long as it is for diabetes monitoring, and the member's plan has a zero copayment for diabetic supplies and equipment, the DME copayment would not apply.</p> <p>The following are some examples of diabetic supplies and equipment that are considered DME:</p> <ul style="list-style-type: none"> • Insulin pumps and all related necessary supplies (including but not limited to insulin for insulin pumps, tubing, syringe reservoir, special needles, sensors) for members meeting medical guidelines • Blood glucose monitors and modified blood glucose monitors and supplies to assist the visually impaired • Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin • Reusable pen delivery devices (for the administration of insulin) <p>The following are some examples of diabetic supplies and equipment that are considered prescription drug benefits:</p> <ul style="list-style-type: none"> • Glucagon • Blood glucose test strips • Lancets and lancet puncture devices • Disposable pen delivery systems (for the administration of insulin) • Cartridges for reusable pen delivery systems <p>Note: For members with an outpatient prescription drug benefit, refer to the SOB or the rider for copayment information. For diabetic members who do not have the outpatient prescription drug benefit, these items except for Insulin are covered under the medical benefit.</p> <p>Insulin: Insulin and other medications are covered by the outpatient prescription drug benefit only.</p> <p>The following are some examples of diabetic supplies and equipment that are considered corrective appliances/ orthotics:</p> <ul style="list-style-type: none"> • Podiatry devices to prevent or treat diabetes related complications including foot/shoe inserts and therapeutic shoes. <p>Note: For members with a copayment for Prosthetics, Corrective Appliances/ Orthotics, (Non-Foot Orthotics), refer to the section below on Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics).</p>
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/ Orthotics (Non-Foot Orthotics), Ostomy/ Colostomy Supplies, and Medical Supplies Used In Conjunction with the Above Items	<p>Some members may have a copayment for DME. For these members, the following guidelines apply:</p> <ul style="list-style-type: none"> • The copayment assessed is only once "per item" and is the same whether the item is rented or purchased. The member should not be charged a monthly copayment. • DME Items that require supplies as part of the initial setup (e.g., Oxygen), require only one copayment. Supplies that require intermittent restocking (e.g., Oxygen Tanks) are not assessed a copayment. However, a copayment is assessed when then primary device item or a necessary accessory (e.g., Oxygen Mask) is replaced or repaired. • For necessary DME repairs, the member is assessed a copayment only when the DME cannot be repaired and needs to be replaced, unless the replacement is necessary due to a device defect that is covered under the device's warranty. Repairs are performed by the vendor under contract. <p>For Corrective Appliances/Orthotics, Prosthetics:</p> <ul style="list-style-type: none"> • A copayment for ostomy/colostomy supplies and catheters is due per 30-day supply. • A copayment for enteral nutritional therapy is due per 30-day supply. • For shoes/foot orthotics/inserts, the member should be assessed a single copayment for a pair of shoes/foot orthotics whether billed as a pair (one HCPCS code identified as per pair) or individually (one HCPCS code with modifier LT and one HCPCS code with RT). If a claim is billed with both shoes and inserts, one copayment should be applied to the pair of shoes and another copayment should

Benefit	Copayment Guidelines
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Ostomy/Colostomy Supplies, and Medical Supplies Used In Conjunction with the Above Items (continued)	<p>be applied to the pair of inserts.</p> <p>Note: A pair of therapeutic shoes is covered even if only one foot suffers from diabetic foot disease (each shoe is equally equipped so that the affected limb, as well as the remaining limb, is protected).</p> <ul style="list-style-type: none"> For corrective appliances/orthotics, prosthetics that include multiple components, only one copayment will be assessed to the main device (e.g., Custom knee brace with multiple components). <p>Note: In instances where the contracted rate of the payer with financial responsibility is less than the member's copayment, the member will pay only the amount of the contracted rate.</p>
Emergency and Urgent Services	<p>Certain coverage plans have a distinct copayment structure for emergency room services and urgently needed services. When the plan code data identifies different copayments for these services follow the guidelines below:</p> <ul style="list-style-type: none"> An Emergency Room copayment is applicable when: the member receives care in the Emergency Room An Urgent Care copayment is applicable when the member receives in-area or out-of-area urgent care from a "non-affiliated" urgent care center A PCP office visit copayment is applicable when: <ul style="list-style-type: none"> The member receives urgent care from his/her PCP The member is directed to a contracted urgent care center by the Medical Group/IPA/PCP, for primary care physician services The urgent care center is used as an after-hours clinic or overflow during business hours When the member is admitted as an inpatient (including psychiatric facilities) following an ER visit, the ER copayment may or may not be waived depending on the member's enrollment plan If the plan code data does not identify distinct copayments for these services the member is only responsible for an office visit copayment for urgent care services; if the member is treated in the emergency room the member is responsible for an emergency room copayment
Family Planning: Contraception, Tubal Ligation/ Sterilization	Refer to the Medical Management Guideline titled <i>Preventive Care Services</i> for specific information on services that may fall under preventive care due to the expanded women's preventive health mandate.
Hearing Aid: Standard	A copayment for the hearing aids may or may not apply. Refer to the specific SOB.
Hospitalization: Inpatient	<ul style="list-style-type: none"> The inpatient hospitalization copayment applies when the member has been admitted (or logged) into the hospital as an inpatient admission, regardless of the actual length of stay. The ER copayment may or may not be waived depending on the member's enrollment plan. For members admitted to the hospital prior to the end of the current benefit plan and who remained hospitalized, the copayment from the previous year's coverage plan applies until the member is discharged or is transferred to another level of care. The member is responsible for one copayment for the entire admission, even if the member is subsequently transferred to another hospital during the same course of stay because: <ul style="list-style-type: none"> The first hospital is unable to sufficiently render the medically necessary care and/or; The member is transferred at the request of the PMG/IPA. Anesthesia: There is no copay for anesthesia related to regular surgery.
Immunizations/Vaccinations	Refer to the Medical Management Guideline titled <i>Preventive Care Services</i> . A copayment for preventive care services should not be taken.
Infertility: Basic Services	Refer to the member's EOC/SOB.
Maternity/Newborn Inpatient	The member may have a copayment for maternity care and a copayment for newborn care depending on the coverage plan purchased by the employer group. The newborn copayment applies only if the newborn is not discharged at the same time as the mother.

Benefit	Copayment Guidelines
Maternity/Newborn Care	<p>Refer to the Medical Management Guideline titled <i>Preventive Care Services</i> for specific information on services that may fall under preventive care due to the expanded women’s preventive health mandate.</p> <ul style="list-style-type: none"> • Member may have an office visit copayment (PCP or Specialist) for the initial visit to diagnose the pregnancy. • Other specialist recommendations for services must be coordinated and reviewed by the primary OB/GYN in order for the recommended services to be covered (e.g., MRI, CT, etc.). There may be additional copayment(s) if the services are determined not to be related to a complication of pregnancy.
Medications: Chemotherapy	<p>Note: The chemotherapy drug benefit is not called out in the SOB, therefore it is currently being loaded in the plan with the O/P injectable drug copayment amount. The copayment for chemotherapy drugs should actually be applied based on the form of administration.</p> <p><i>Example:</i></p> <ul style="list-style-type: none"> • Chemotherapy is given by SQ or IM Injection. The O/P injectable drugs copayment applies. • Chemotherapy is given by IV infusion. The infusion therapy copayment applies. <p>Note: Refer to <i>Medications: Infusion Therapy</i> and <i>Medications: Injectable</i> sections below for further details/specifics.</p>
Medications: Infusion Therapy	<p>For members with a copayment for infusion therapy:</p> <ul style="list-style-type: none"> • The member is responsible for a copayment per 30 days or treatment plan, whichever is shorter unless the SOB states otherwise. This applies whether the medication is infused in the member's home, outpatient facility, or physician's office. For drugs infused in the member's home through Home Health, both the Infusion Therapy copayment and the Home Health copayment are applied. For drugs infused in the physician's office, both the Infusion Therapy copayment and the physician's office Visit copayment are applied. • There is no separate facility copayment when infusion services are administered at a hospital in an outpatient setting or at an outpatient surgery facility. • For medications administered through an infusion pump, the DME copayment applies. <p>Note: The infusion therapy copayment is not dictated by the number of infused medications the member receives during the course of the therapy.</p> <p>In instances where the contracted rate of the payer with financial responsibility is less than the member’s copayment, the member will pay only the amount of the contracted rate.</p>
Medications: Injectable	<p>For members with an injectable medication copayment the following guidelines apply:</p> <ul style="list-style-type: none"> • For injectable medications administered in the physician's office, the member is responsible for a copayment per visit. Note: This does not apply to all plans. For some plans, copayment may apply per 30 day supply or treatment plan, whichever is shorter. Check the member's SOB. • For self-injectable medications, a copayment applies per 30 day supply or treatment plan, whichever is shorter. • When an injectable medication is administered to a member in the physician's office, only the Injectable Medication copayment is assessed. The copayment for the Physician Office Visit is not assessed if the administration of the injection was the primary reason for the member's visit. Exception: A separate Office Visit copayment is applicable if the member receives an injection for a medication that specifically requires a physician to administer. • The Injectable Medication copayment should not be applied in the following instances: 1) inpatient care, 2) outpatient surgery at a participating free-standing or outpatient surgery center or 3) skilled nursing facility services or 4) urgent care center. • The Injectable Medication copayment is not dictated by the number of injectable medications the member receives during the course of the office visit. • In instances where the contracted rate of the payer with financial responsibility is less than the member’s copayment, the member will pay only the amount of the contracted rate.

Benefit	Copayment Guidelines
Medications: Injectable (continued)	Note: Certain J codes are not always injectable. If the medication is assigned a J code but it is being applied topically. A copayment for injectable drug would not apply (e.g., Apligraf, Levulan).
Nutritional Therapy (Enteral, Parenteral and Oral)	Enteral and Parenteral Nutrition: <ul style="list-style-type: none"> A copayment applies per 30-day supply for enteral or parenteral nutritional supplies. Refer to the service code that correlates to prosthetic supplies in the plan code data.
Outpatient Medical Rehabilitation Therapy	<ul style="list-style-type: none"> Copayment applies per visit for physical, occupational, speech, and cardiac rehabilitation therapies. Note: The rehabilitation benefit is administered based on treatment episode. Benefit can be renewed within the calendar year if there is a change in the original condition that warrants additional days of rehabilitation. <ul style="list-style-type: none"> Complex decongestive physiotherapy (CDP) is considered a medical treatment rather than rehabilitation/therapy. Therefore, the outpatient medical rehabilitation therapy copayment should not be assessed for CDP nor is it subject to the rehabilitation/therapy benefit maximum.
Physician Office Visits Including Primary Care/ Specialist Visits and Telephonic/Online Consults/ Coumadin Clinics/Physician Home Visits	General physician office visit copayment assessment rules: <ul style="list-style-type: none"> The physician office visit copayment may be assessed only if services are rendered by any one of the following licensed practitioners: <ul style="list-style-type: none"> A physician [either doctor of medicine (M.D.) or doctor of osteopathy (D.O.)] A nurse practitioner (NP or FNP) A physician's assistant (PA) A podiatrist An audiologist An optometrist A doctor of pharmacy (PharmD) at a Coumadin clinic/facility as long as the PharmD is (1) licensed by the state and is performing within the scope of practice and (2) is performing under the direct supervision of an MD or DO. The M.D. or D.O. does not have to be physically present in the room with the patient while services are provided, but must be present in the office suite to render assistance, if necessary. The physician office visit copayment cannot be assessed at a freestanding Coumadin clinic that is not under the supervision of an MD or DO. The physician office visit copayment may not be assessed if services are rendered solely by one of the following licensed practitioners: <ul style="list-style-type: none"> A nurse A medical assistant A dietician or nutritionist Any other licensed non-physician practitioners not listed above The physician office visit copayment does not apply to telephonic/online consults. The copayment can only be assessed when the healthcare professional sees the member in person. Visits by a physician to the member's home or residential/custodial facility are categorized under the member's home health care benefit. Therefore, the home health care copayment is applied to each physician home visit and is subject to any limits under the member's home health care benefit. Members are not responsible for a physician office visit copayment if the visit is during the pre-operative or post-operative global surgery period. Split copayment plan rules: <ul style="list-style-type: none"> Some coverage plans require a different copayment for a PCP office visit than for a specialist office visit. These are known as split copayment plans. Refer to the UnitedHealthcare West SignatureValue plan code data to identify members with these coverage plans. Services performed by other licensed non-physician practitioners (except for nutritionists and dieticians) may be assessed the specialist office visit copayment. Services performed by nutritionist and dieticians may not be assessed any physician office visit copayment. When an injectable medication is administered to a member in the physician's

Benefit	Copayment Guidelines
Physician Office Visits Including Primary Care/ Specialist Visits and Telephonic/Online Consults/ Coumadin Clinics/Physician Home Visits (continued)	office, only the Injectable medication copayment is assessed. The copayment for the physician office visit is not assessed if the administration of the injection was the primary reason for the member's visit. Exception: A separate office visit copayment is applicable if the member receives an injection for a medication that specifically requires a physician to administer.
Plan Changes in Middle of Care	The member's benefit at the time of admission is the benefit that will be applied until the member is discharged.
Specialized Scanning and Imaging Procedures	Certain coverage plans require a copayment for specialized scanning and imaging procedures, which includes but is not limited to CT Scans, MRIs, SPECT and PET scans: <ul style="list-style-type: none"> • The copayment applies per procedure (per CPT code billed). • The copayment is applied to the vendor or facility. The copayment is not applied to the professional component for these services. • The copayment applies only when the member visits the facility specifically for the purpose of receiving a specialized scan/imaging procedure. The copayment is not assessed if the member has the specialized scan/imaging procedure performed either in the ER or in conjunction with an ER visit (ER copayment would still apply). Note: In instances where the contracted rate is less than the member's copayment, the member will pay only the contracted rate.
Vision Screening and Vision Refraction	<ul style="list-style-type: none"> • For members receiving vision screening services during a physician office visit, only one copayment applies. • If vision refraction is performed in addition to vision screening during a physician office visit, only one copayment applies.