

How to Determine an Insurance UUID Using Plan Information.

Purpose: The purpose of this document is to assist in the process of figuring out how to map a plan to a H1 insurance object. For more context on the complex relationship between plans, networks, and H1 UUIDs read the following [background information](#).

Determining the Correct H1 UUID

H1's insurance network names closely match the names listed on a payer's website. Therefore asking your clients to provide the plan/network name as listed on the payer's website is often the simplest way to identify the relevant H1 insurance network and corresponding UUID. When clients are not able to provide this information, official plan documents released by payers are often a great source to potentially figure out what the corresponding network would be. In particular, three types of plan documents (*Summary of Benefits*, *Schedule of Benefits*, and *Evidence of Coverage*) might contain relevant information about the network.

Helpful Steps for Determining the Network or H1 Insurance Object

1. Ask your client to provide the plan/network name as listed on the payer's website.
 - a. More details around the relationship between H1 insurance networks names and payer website information can be found [here](#)
2. Navigate to the payer's website (i.e. aetna.com) and try to find the plan in question via "Shop for a Plan" menu-item on the insurance companies website.
 - a. If you are able to find the plan info on the website, read over the relevant marketing information to see if there is any mention of the specific network that underpins the plan.
3. Ask your client for the relevant benefit documents for the plan in question.
4. For each document obtained, check for mention of what network is being leveraged by the plan. See the linked appendix sections below to learn more about documents and where network information might be found within each file.
 - a. [Summary of Benefits and Coverage](#) (SBC)
 - b. [Schedule of Benefits](#) (SOB)
 - c. [Evidence of Coverage or Benefit Handbook](#)

- If none of the plan documents provide information about insurance networks that match up with H1 values, it may be helpful to reach out to Essentials Support team at resellers@jellyvision.com for further support.

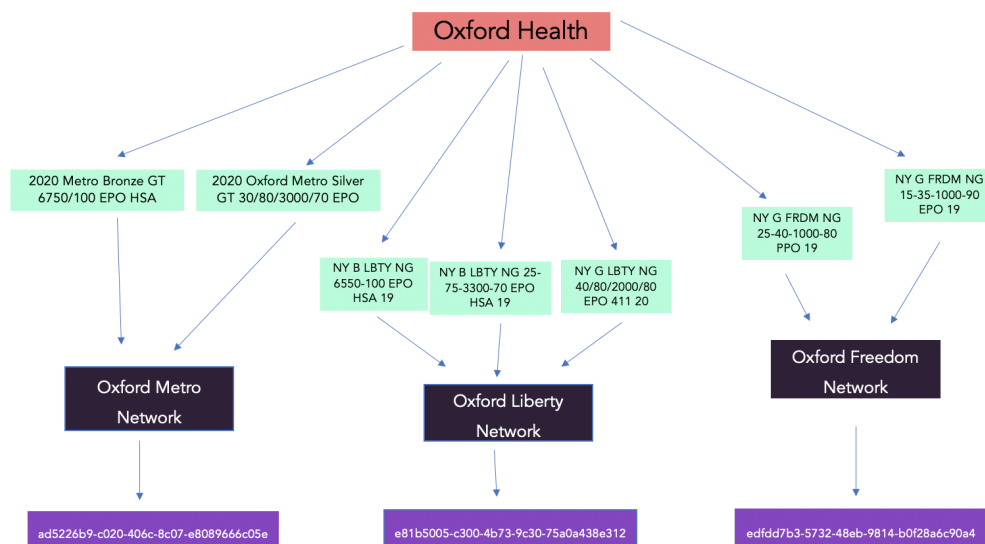
APPENDIX

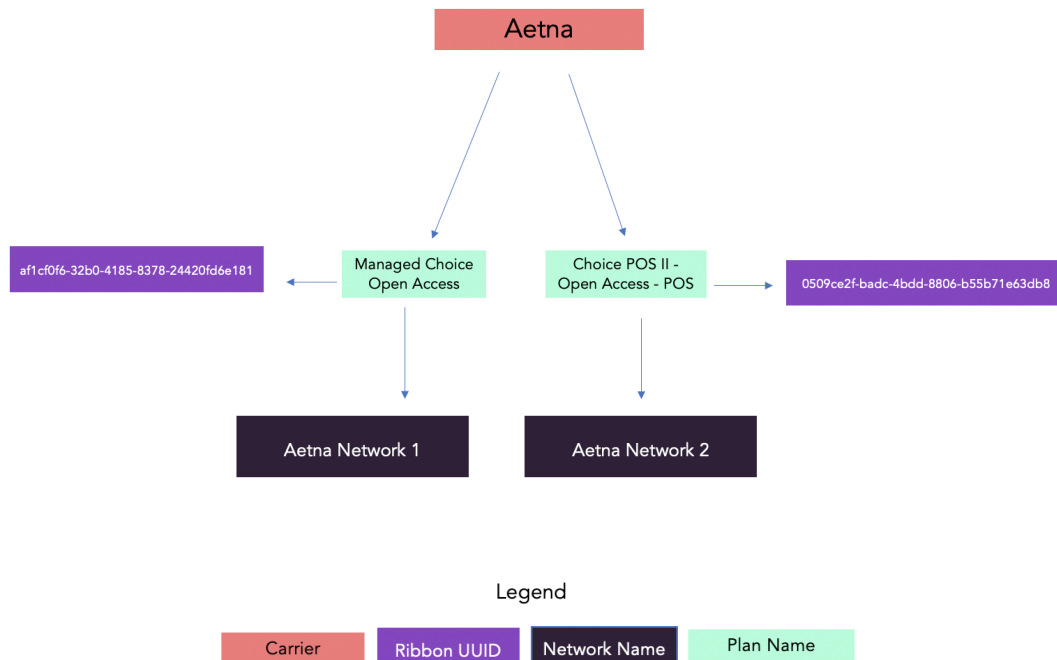
Overview of Relationship between Plans, Networks and UUIDs

An H1 UUID can represent either an insurance network or an insurance plan. A carrier (e.g., Aetna) may have thousands of distinct insurance plans. Each of these insurance plans is associated with a network. Multiple insurance plans may share the same network, or one plan could be associated with one distinct network, created by the carrier with that one particular plan in mind.

The visuals below display the relationship between H1 Insurance UUIDs and the overall healthcare ecosystem.

In the Oxford Health example, you will see how individual plans are associated with a network, which, in turn, are associated with a H1 UUID. For Aetna, however, the network names are not published. Therefore each plan is associated with a distinct H1 UUID.





Relationship between H1's Insurance Names + Information Listed on Payer's Website

H1's insurance network names closely match the names listed on a payer's website. Therefore, working with your clients to determine the plan/network names as listed on the payer's website that is associated with their particular plans will greatly assist in determining the relevant UUID. In the below example, you can see the Aetna network names as listed on Aetna's website.

Networks on Aetna's Website

Aetna Open Access Plans	
☐	Aetna Choice® POS II (Open Access)
☐	Aetna Health Network Only SM (Open Access)
☐	Aetna Health Network Option SM (Open Access)
☐	Aetna Select SM (Open Access)
☐	Elect Choice® EPO (Open Access)
☐	Managed Choice® POS (Open Access)

Ribbon Network Names

Aetna - Choice POS II - Open Access - POS

Aetna - Health Network Only (Open Access)

Aetna – Health Network (Open Access)

Aetna - Select - Open Access

Aetna - Elect Choice (Open Access) - EPO

Aetna - Managed Choice (Open Access) - POS

Document Overview

Summary of Benefits and Coverage (SBC)

A Summary of Benefits and Coverage (SBC) is a document that provides consumers with a concise summary of a plan's benefits and coverage. This includes information on what services are covered by the plan and how much co-pay, coinsurance, deductibles a patient can expect to pay. The format of all SBCs documents are uniform allowing consumers to compare the benefits of a plan one-to-one.

There are two specific parts of an SBC document that can potentially provide helpful information about the network associated with the plan.

1. The top of first page an SBC includes plan nomenclature information which always call out the plan name and **sometimes** call out the network name
 - a. In the example below, *Harvard Pilgrim Best Buy Tiered Copayment* is the plan name and *ChoiceNet HMO* is the network name.
2. The top of the first page also includes information about the plan-type (HMO, PPO, etc.). This information can be extremely helpful for figuring out the correct network for smaller payers as they often only have one or two networks for each plan-type. H1 data for commercial plans includes info on plan type that can be used to do this mapping.
 - a. In the example below this plan is designated as an HMO plan.

- If steps #1 and #2 don't yield any results, it may still be helpful to search the document for any mention of the word *network* to see if any additional information can be gleaned.



Harvard Pilgrim
HealthCare

Massachusetts

1

Harvard Pilgrim Health Care, Inc.

The Harvard Pilgrim Best Buy Tiered Copayment
ChoiceNetSM HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 2012-2013

2

Coverage for: Individual + Family Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.dol.gov/ebsa/healthreform or by calling 1-888-333-4742.

Important Questions	Answers	Why this matters:
What is the overall deductible?	Tier 1 Providers: \$1,000 per Member per Plan Year / \$2,000 per Family per Plan Year Tier 2 Providers: \$1,500 per Member per Plan Year / \$3,000 per Family per Plan Year Tier 3 Providers: \$2,000 per Member per Plan Year / \$4,000 per Family per Plan Year The deductible applies to benefits specifically cited in the chart starting on Page 3. For other benefits see your Plan document.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible. Primary Care Physicians, Specialists, Hospitals that are preferred providers are placed in one of "three" tiers. Members' cost sharing depends on the providers they use. Tier 1 providers are the lowest cost. Tier 3 providers are the highest cost.

Example Taken from Harvard Pilgrim Insurance

Schedule of Benefits (SOB)

A Schedule of Benefits is a document that outlines the fees associated with each type of health care service covered by your plan. This includes copays, coinsurances, deductibles, and out-of-pocket expenses.

The first page of these documents can **sometimes** contain information about the network that underpins the plan. An example is below:



attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate
HMO (1-1-2020)

Schedule of Benefits

HMO Blue Select

\$1,000 Deductible with Copayment

This is the *Schedule of Benefits* that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you will have to pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. **Be sure to read all parts of your Subscriber Certificate to understand the requirements you must follow to receive all of your coverage. You should also read the descriptions of covered services and the limitations and exclusions that apply for this coverage.** All words that show in italics are explained in Part 2. **To receive coverage, you must obtain your health care services and supplies from covered providers who participate in your health plan's provider network.** Also, for some health care services, you may have to have an approved referral from your *primary care provider* or approval from your health plan in order for you to receive coverage from your health plan. These requirements are fully outlined in Part 4. If a referral or an approval is required, you should make sure that you have it before you receive your health care service. Otherwise, you may have to pay all costs for the health care service.

This health plan is a limited provider network plan.

Your health plan has **a limited provider network called HMO Blue Select.** This limited network plan provides access to a network that is smaller than the full HMO Blue network. Under this plan, *members* have access to network benefits only from the providers in the HMO Blue Select network. Please consult the HMO Blue Select network provider directory to determine which providers are included in the limited network. The *service area* where your *covered services* will be furnished includes all counties in Massachusetts, except Barnstable, Dukes, and Nantucket Counties. See Part 1 for information about how

Example taken from BCBS of Massachusetts

As always, it may still be helpful to search the document for any mention of the word *network* to see if any additional information can be gleaned.

Evidence of Coverage or Benefit Handbook

An Evidence of Coverage or Benefit Handbook is a comprehensive document that explains in great detail all the benefits and terms associated with a plan. This document will break down all the specifics about how different aspects of the plan will work for the consumer. These documents can sometimes be over 100 pages long.

Depending on the payer these documents can **sometimes** explicitly call out the network name. As such it may be helpful to search the document for any mention of the word *network* to see if any additional information can be gleaned.

Information from State Exchanges

Certain states maintain information about health insurance products that are valid within their state either due to regulation or the creation of state-level insurance exchanges. The health plan

product documents listed on the state website sometimes explicitly call out the insurance plans that go with each network.

As an example, the State of Massachusetts has an entire directory of all their health plan products available [here](#). For a specific example, see their HMO specific plan [directory](#) which calls out the plan to network relationship.