Getting the Most From Your Health Care Coverage

Health care coverage can sometimes be complex and confusing, but it doesn't have to be. This guide is designed to help you get the most from your UnitedHealthcare benefits.[1] We work with the National Committee for Quality Assurance® (NCQA®) and state and federal regulators to ensure members receive this information on an annual basis.

Important note: Not all information provided in this document is applicable to all enrollees. Some information may not apply if your plan does not provide certain coverage, products and/or services referenced herein. Your plan document (Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage), including all of its Riders, amendments or summary of material modifications, contains a complete listing of the terms and conditions of your coverage and prevails in the event of any conflict between this document and your plan document.

In addition, information in this document 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 plan document for specific information on your benefits or refer to your member website for the most up-to-date information.

Getting Answers to Your Questions

Information about your health care benefits is just a click or phone call away.

Sign in to **myuhc.com**® for personalized information and helpful tools to help you manage your health and your health care dollars.

- **Coverage & Benefits:** Learn whether a service is included or excluded from coverage and if notification is required, the coverage levels for different types and places of care, and your copayment, coinsurance and deductible amounts (as applicable).
- **Claims & Accounts**: Check your claims status and find out what has been paid and the amount you are responsible for paying. If you use our network of providers, you won't have to submit a claim. There's also information on how to submit an appeal if you disagree with our payment decision.
- **Find Care & Costs**: Find a network facility, doctor or other healthcare provider. You can also view average costs of health care services in your area.
- **Pharmacies & Prescriptions**: get pharmacy benefit information including notification requirements, supply limits or step therapy requirements, if applicable. You can also price medications, look for lower-cost alternatives, locate a network pharmacy, refill prescriptions, or check the status of your order at our Mail Service Pharmacy.[2]
- **Print an ID card**: print a temporary health plan ID card and request a new card.

[1]Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by or through UHC of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Washington, Inc. Administrative services provided by United HealthCare Services, Inc., OptumRx or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

[2]For plans that include pharmacy benefits provided by UnitedHealthcare or OptumRx. All trademarks are the property of their respective owners.

If you don't have access to a computer or if you have any questions, please call us at the toll-free phone number on your health plan ID card, TTY/RTT 711, or message us on **myuhc.com**.

The UnitedHealthcare® app makes it easy to find nearby doctors, check the status of a claim, see your account balance or view your ID card. You may even be able to video chat with a doctor–all from your smartphone or tablet.[3]

Clinical Services

Clinical Services is a department that includes our notification unit and inpatient and outpatient care programs. If you have questions about a preauthorization (coverage approval) or your use of medical services, call the toll-free phone number on your health plan ID card, TTY/RTT 711. Language assistance is also available at this same toll-free number.

How to submit a complaint

When you have a complaint, call the phone number on your health plan ID card for information on how to voice a complaint or grievance. When your complaint is related to your medical care, we will communicate with doctors to address your concerns. If it relates to another service, we will investigate the situation. Managed care members in California can also find a form that can be used to submit a grievance by signing into **myuhc.com** and selecting myClaims Manager then Member Appeals and Grievances.

You have the right to file a formal grievance about any of your medical care or services. To file, please use this form. You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department. There is a process you need to follow to file a grievance. UnitedHealthcare, by law, must give you an answer within 30 days.

If you have any questions, or prefer to file this grievance orally, please feel free to call us at 1-800-624-8822 or 1-800-422-8833 (TDHI), Monday through Friday, 7 a.m. to 9 p.m. If you think that waiting for an answer from UnitedHealthcare will hurt your health, call and ask for an "Expedited Review".

Questions or concerns about benefit determinations

If you have questions or concerns about a benefit determination, call the phone number on your health plan ID card. When you want UnitedHealthcare to reconsider a denial of coverage, or payment for a service, contact us for information on how to file an appeal. Refer to your enrollee materials for an explanation on how to submit an appeal.[4] Your enrollee materials also include the address where you can mail an appeal.

When requesting an appeal of a benefit determination, include the following information:

- Patient's name and identification number from the health plan ID card
- The date(s) of medical service(s)
- The physician's/health care professional's/facility's name
- The reason you believe the claim or benefit should be paid
- Any documentation or other written information to support your request for claim payment or benefit coverage

[3]The UnitedHealthcare® app is available for download for iPhone® or AndroidTM. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC. 24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, in all locations or for all members. Data rates may apply.

[4]Federal employees should refer to their Federal Brochure RI 73-49 for specific appeals processes.

You or your authorized representative may submit any written comments, documents, records, or other information you feel is relevant. You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents, records and other information relevant to your claim benefits. If someone submits an appeal on your behalf, we may require written authorization from you allowing that person to act as your authorized representative.

External review program

If following completion of the internal appeal process, you remain dissatisfied with the outcome of a clinical review, you may have the right to appeal the decision to an independent review organization. This process is called an independent external review or IER.[5] Please review your plan documents, or your appeal determination letters, for information about eligibility to appeal the decision to an independent review organization.

In most states, IER is based on the necessity of medical treatment or services.[6] But it may include other types of denials as well. The state regulatory agency makes arrangements to have your case reviewed. In these instances, independent physicians who have no relationship with UnitedHealthcare will conduct this review. In some cases, the reviewers will support UnitedHealthcare's decision. In others, they may not. To learn how to request an IER, refer to your enrollee materials.

For enrollees in California, the California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first call UnitedHealthcare at 1-800-624-8822 or 1-800-442-8833 (TDHI) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDHI line (1-877-688-9891) for the hearing and speech impaired. The department's website, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

Getting the Right Care at the Right Place

UnitedHealthcare has one of the largest direct contracted networks in the nation with over 1.2 million doctors and health care professionals and over 6,300 hospitals. UnitedHealthcare’s pharmacy network includes major national and regional pharmacy chains and most independent local pharmacies. Please check your enrollee materials or call the phone number on your health plan ID card for more information.

For members enrolled in an HMO/MCO product, one of the first things you are asked to do is to select a Primary Care Physician (PCP). This is a doctor who is contracted with UnitedHealthcare and who is primarily responsible for the coordination of your health care services. A PCP is trained in internal medicine, general medicine, general practice, family practice, pediatrics or obstetrics/gynecology. Please refer to your Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage for how your plan defines a PCP. Unless you need Emergency or Urgently Needed care, your PCP is your first stop for using medical benefits. Your PCP will also seek authorization for any referrals, as well as initiate any necessary Hospital Services.

[5]In Texas, Oklahoma, Oregon and Washington, this process is called an IRO – Independent Review Organization. In California, this process is called IMR – Independent Medical Review.

[6]Additional qualifications may apply. Refer to your enrollee materials for complete details.

If your ID card states "Referrals Required," you'll need an electronic referral from your PCP before seeking services from another network provider. Without it, your care may not be covered and you may end up paying more.

Finding a network health care provider

Sign in to **myuhc.com** to find information on network doctors and other health care professionals who can meet your need for primary care, specialty care or behavioral health care, if applicable. You can search and filter by name, specialty, location and other options. Information on network hospitals and other health care facilities can also be found here. Selecting a physician and facility from our contracting/participating network will provide you with maximum benefits from your health plan. You may choose to seek care outside of our contracting/participating network without a referral; however, you should know that **care received from an out-of-network physician, facility or other health care professional, for anything other than emergency care, may not be covered or may result in a higher deductible and copayment.** Always confirm the network participation of both the health care professional and the facility before receiving health care services.

If you are not able to view our online directory, or for more information on the professional qualifications of a network provider, call the phone number on your health plan ID card. A representative will provide you with the information or have a printed copy of the network directory sent to you.

If you need covered health care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your doctor or a representative acting on your behalf can ask for an exception, or referral, to an out-of-network provider. To request a referral to an out-of-network provider, call the toll-free member phone number on your health plan ID card. For mental health and substance use disorder services, call the Mental Health phone number on your ID card. 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.

Where to go for medical care

Your plan includes coverage for various types of care. Where to go for medical services depends on your health care needs. If you are not sure what type of care you need, use the guidelines below.

For **routine or primary/preventive care,** it is best to go to your own doctor's office. It's important to establish a relationship with a primary care doctor who knows your health history and that you can call when you need care. For help finding a primary care physician (PCP), search our online provider directory or call the phone number on your health plan ID card.

Another option to consider for non-emergency health conditions is a virtual visit. A virtual visit lets you see and talk to a doctor from your computer or mobile device, without an appointment.[7] Sign in to **myuhc.com** or the UnitedHealthcare® app to learn more.

For **hospital care**, talk with your PCP to determine which hospital is best for your medical/surgical needs. Your benefit plan may require you or your physician to notify UnitedHealthcare of a hospital admission.

[7] 24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your plan benefits to determine if these services are available. Data rates may apply.

For **care after hours**, first call your PCP. Primary care physicians provide either an answering service or a detailed answering machine message with instructions for accessing care after hours.

- **Is it urgent?** – Please check your Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for how your plan defines urgent care. Typically, it is health care services, provided in a situation other than an emergency, that are typically provided in a setting such as a physician's or provider's office or an urgent care center.

  Enrollees in California can find information on urgent care centers by logging into **myuhc.com**, and searching for "CA Medical Group and Urgent Care Information" in the provider search tool.

- **Is it an emergency?** – Please check your Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for how your plan defines emergency care. Typically, emergency care is care to treat symptoms (including severe pain) that are so critical that a reasonable layperson believes they could result in the following if medical care is not received right away:
  – Serious jeopardy to an individual's health
  – Serious impairment to bodily functions
  – Serious dysfunction of any bodily organ or part
  – Serious disfigurement
  – Serious jeopardy to the health of a pregnant woman or to the health of her unborn child.

In an emergency, no matter if you are at home or out of town, call 911, or its local equivalent, or go to the nearest emergency room.

Finding care if you are out of town or state

As an enrollee of a UnitedHealthcare health plan, you are covered for urgent and emergent care[8] wherever you are. If, while you are out of town, you need medical attention for an unforeseen illness, injury or condition, your first step should be to call your PCP or UnitedHealthcare for instructions. If you are unable to make this call, you may go to a local doctor or urgent care center for treatment.

As an enrollee of a UnitedHealthcare plan, you are covered for emergent care wherever you are. In the event of an emergency anywhere in the world, go to the nearest hospital emergency room or call 911, or its local equivalent.

Be sure to tell your PCP or UnitedHealthcare that you've received emergency or urgent care while out of town. Call within 48 hours, or as soon as reasonably possible, after receiving care.

Filing a claim with UnitedHealthcare

When you visit contracted/participating practitioners and health care facilities in the UnitedHealthcare network, you rarely have to worry about receiving a bill. That's because they send their claims to us directly.

If you receive a bill from a practitioner or health care facility for a visit for a particular service, call the phone number on your health plan ID card. A representative can help you determine if any part of the claim is your responsibility.

Our representative may ask you to submit a claim if the bill is for a covered service and we don't have your claim on file. The representative can tell you where to send it and what information it needs to include. No form is needed. Just send the bill to the address on your health plan ID card, along with a letter explaining the reason you are submitting the claim.

[8]For definitions of terms, refer to the definitions above.