UnitedHealthcare Choice
UnitedHealthcare Core
UnitedHealthcare Navigate®

Description of Coverage for UnitedHealthcare of Illinois, Inc.

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions (including external independent reviews).
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet.

SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at (877) 527-9431.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

In addition to the benefit summary enclosed, UnitedHealthcare would like to provide you with the following information.

Service Area

Boone, Cook, DeKalb, DuPage, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, McHenry, Will and Winnebago

Prior Authorization

We require prior authorization for certain covered health services. In general, your primary physician and other[1] network providers are responsible for obtaining prior authorization before they provide these services to you. There are some benefits however, for which you are responsible for obtaining prior authorization. The services for which prior authorization is required are identified in the enclosed benefit summary within each covered health service category.

1 Applies to Navigate® only. Please note that prior authorization is required even if you have a referral from your primary physician to seek care from another network physician.

We recommend that you confirm with us that all covered health services listed below have been prior authorized as required. Before receiving these services from a network provider, you may want to contact us to verify that the hospital, physician and other providers are network providers and that they have obtained the required prior authorization. Network facilities and network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for Customer Care on your health plan ID card.

To obtain prior authorization, call the telephone number for Customer Care on your health plan ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a medically necessary covered health service, you will be responsible for paying all charges and no benefits will be paid.

To notify us, call the telephone number for Customer Care on your health plan ID card.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

For additional information about the care management process, please contact the Customer Care phone number on the back of your health plan ID card or access myuhc.com®.

Emergency Care

Benefits apply to covered health services that are provided by a network physician or other network provider. Benefits for facility services apply when covered health services are provided at a network facility. Benefits include physician services provided in a network facility by a network or a non-network anesthesiologist, emergency room physician, consulting physician, pathologist and radiologist. Emergency health services and covered health services received at an Urgent Care Center outside your geographic area are always paid as network benefits.

If you are confined in a non-network hospital after you receive outpatient emergency health services, you must notify us within one business day. If your medical condition prevents you from notifying us within one business day, you must notify us as soon as reasonably possible. Once the attending physician determines that your condition is stable and we determine that there is no medical reason why you cannot be transferred to a network hospital, we will notify you that for network benefits to continue, you must transfer to a network hospital. If you choose to stay in the non-network hospital after receiving the notice, the benefit level will revert to the lower non-network benefit for the remainder of the stay.

Access to Specialty Care

UnitedHealthcare has the nation's largest single proprietary network with 751,609 physicians and health care professionals and 5,629 hospitals.

To find a physician you can access myuhc.com and select the find physician, laboratory or facility link. Here you can find information on network physicians who can meet your need for primary care, specialty care or mental health care, if applicable. Hospitals and other health care facilities can also be found here.

Choosing a physician and facility from our network will provide you with maximum benefits from your health plan. You may choose to seek care outside of our network; however, you should know that care received from a non-network physician, facility or other health care professional, for anything other than emergency care, may result in a higher deductible and copayment. Some plans do not provide benefit coverage for care from physicians or facilities outside of our network.

Out-of-Area Coverage

Finding care if you are out of town or state

Coverage for medical emergency care that cannot be reasonably postponed until the enrollee returns home may be covered.

Call the Customer Care phone number on the back of your health plan ID card to find physicians and health care facilities near your location, and to learn if any restrictions apply. Or, if your plan includes Care24® or NurseLine℠, you can contact the toll-free, 24-hour help line for help finding the care you need.

Continuity of Treatment

If your health care provider's participation in UnitedHealthcare's network terminates and at the time of such termination you are undergoing a course of treatment with that health care provider, you may be able to continue an ongoing course of treatment with the health care provider for a certain amount of time. Please contact your healthcare provider or Customer Care to determine whether transition of care services are available to you. The telephone number for Customer Care is provided on the back of your health plan ID card.

Appeals Process

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact Customer Care at the telephone number shown on your health plan ID card. Customer care professionals are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint or an Appeal

Contact Customer Care at the telephone number shown on your health plan ID card. Customer care professionals are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the customer care professional can provide you with the appropriate address. Part 919 of the Rules of Illinois Department of Insurance requires that we advise you that if you wish to take this matter up with the Illinois Department of Insurance, it maintains Consumer Divisions at the following addresses:

Illinois Department of Insurance
Consumer Division
122 S. Michigan Ave., 19th Floor
Chicago, IL 60603

-or-

Illinois Department of Insurance
Consumer Division
320 West Washington St.
Springfield, IL 62767

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the health plan ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

First Level Review

Step 1

You must present a written complaint to our Customer Care department. You, your designee or guardian, your physician or your health care provider may file the appeal.

Written complaints should be addressed to:

UnitedHealthcare Appeals
PO Box 30573
Salt Lake City, UT 84130

Step 2

We will acknowledge, in writing, the receipt of your appeal within 3 business days and request all the information required to evaluate your case.

Step 3

A formal decision will be made within 15 business days after receipt of all required information. You will be notified orally of the decision and written notice will be sent following oral notification.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 24 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your physician to make a decision, we will notify you orally of the decision within 24 hours following receipt of the required information. Written notice will be sent following oral notification.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Administrative Complaints

If you have a complaint concerning products, services, operations or protocols, you should contact our customer care professionals at the telephone number shown on your health plan ID card.

Customer Care is available to take your calls during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer care professional will return your call. If you would rather send your complaint to us in writing at this point, Customer Care can provide you with the appropriate address.

Exhaustion of Internal Appeal Process

You must first exhaust the internal appeal process before requesting an external review, unless:

- You or your authorized representative have filed an appeal under our internal appeal process and have not received a written decision on the appeal 30 days following the date you or your authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 60 days following the date you or your authorized representative files an appeal of an adverse determination that involves a retrospective review request, except to the extent that you or your authorized representative requested or agreed to a delay;
- You or your authorized representative requested an expedited internal review of an adverse determination but has not received a decision from us within 48 hours after receipt of the information (unless you or your authorized representative agreed to a delay);
- We waive the exhaustion of the internal appeal process requirement;
- You have a medical condition in which the timeframe for completion of:
  - An expedited internal review of an appeal involving an adverse determination;
  - A final adverse determination; or
  - A standard external review would seriously jeopardize your ability to regain maximum function;
- An adverse determination concerns a denial of coverage based on determination that the recommended or requested health care service or treatment is experimental or investigational and your health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. In such cases, you or your authorized representative may request an expedited external review at the same time you or your authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review shall determine whether you are required to complete the expedited review of the appeal prior to conducting the expedited external review; or
- We have failed to comply with applicable State and federal law governing internal claims and appeals procedures.

Standard External Review

Within four months after the date of receipt of a notice of an adverse or final adverse determination, you or your authorized representative may file a request for an external review with the director. Within one business day after the date of receipt of a request for external review, the director will send a copy of the request to us.

We will complete a preliminary review of the external review request within five business days of receipt to determine whether:

- You were a covered person at the time services were requested or provided;
- The services are a covered health service, but we have determined that they are not covered;
- You have exhausted our internal appeal process unless you are not required to exhaust our internal appeal process;
- In the case of experimental or investigational services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your physician; and
- You have submitted all required information and forms.

Within one business day after completing the preliminary review, we will provide written notice to you and the director indicating whether the request is complete and eligible for external review. If incomplete, we will notify you and the director of any missing information needed to complete the request. If ineligible, we will explain the reasons for ineligibility for external review and notify you and the director that you may appeal our decision to the Department of Insurance. The director is authorized to reverse our initial determination and require that the request be referred for external review.

If eligible for external review, within one business day after the date of receipt of the notice, the director will:

- Randomly assign an independent review organization from the director's list of approved independent review organizations qualified to conduct an external review and notify us of the name of the assigned independent review organization; and
- Notify you in writing of the request's eligibility and the name of the assigned independent review organization. The director must also include in the notice a statement that you may, within five business days of the notice receipt, submit in writing to the assigned independent review organization any additional information to be considered by the independent review organization in the review. (The independent review organization is not required to, but may, accept and consider additional information submitted after five business days).

Within five business days of assigning an approved independent review organization, we will send the independent review organization any documents and information considered in making the adverse determination. If we fail to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify us and you within one business day (immediately for experimental or investigational services).

In addition to any documents and information provided by us and you, an independent review organization shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer. Additionally for Experimental or Investigational Services the independent review organization shall also consider FDA approval (if applicable) or medical or scientific evidence or evidence-based standards. Within 20 days after being selected to conduct the external review of the Experimental or Investigational Service, each clinical reviewer must provide to the independent review organization a written opinion on whether the services or treatment should be covered.

The independent review organization must provide written notice of its decision to us, you and the director within five business days after receiving all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review (for Experimental or Investigational Services a written notice must be provided within 20 days after receiving the opinion of each clinical reviewer).

- The independent review organization notice must include a general description of the reason for the external review request, the date it was assigned from the director, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, the principal reason(s) for its decision, and the rationale for its decision.
- For experimental or investigational treatment reviews, the independent review organization notice must also include descriptions of the factors considered by the independent review organization in making its decision.

Upon receipt of a notice of a decision reversing the adverse or final adverse determination, we will immediately approve the coverage that was the subject of the adverse or final adverse determination.

Expedited External Review

You or your authorized representative may request, orally or in writing, an expedited external review with the director:

- After receiving a notice of adverse determination from us if:
    - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or

    - The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated, an expedited external review may be requested at the same time you or your authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether you are required to complete the expedited review of the appeal prior to conducting the expedited external review.
- After receiving a notice of final adverse determination from us if:
    - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for a standard external review;
    - The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received emergency health services but have not been discharged from the facility; or
    - The final adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.
    - We fail to provide a decision on an expedited internal appeal within 48 hours.

Upon receipt of a request for an expedited external review, the director will immediately send a copy of the request to us.

- We will determine whether the request meets the following reviewability requirements:
- You were a covered person at the time services were requested or provided;
- The services are a covered health service, but we have determined that they are not covered;
- You have exhausted our internal appeal process unless you are not required to exhaust our internal appeal process;
- In the case of experimental or investigational services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your physician; and
- You have submitted all required information and forms.

We will notify you, your authorized representative and the director of our eligibility determination.

If determined ineligible for expedited external review, we will also notify you that you may appeal our decision to the director.

Upon receipt of the notice that the request meets the reviewability requirements, the director will:

- Immediately and randomly assign an independent review organization from the director's list of approved independent review organization qualified to conduct external review; and
- Immediately notify us of the name of the assigned independent review organization.

We will provide or transmit (electronically, by telephone, facsimile or any other available expeditious method) to the assigned independent review organization all necessary documents and information considered in making the final adverse determination. We will provide this information immediately upon receipt from the director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice. If we fail to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify us, the director, and you within one business day.

In addition to any documents and information provided by us and you, an independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer. Additionally for experimental or investigational services the independent review organization shall also consider FDA approval (if applicable) or medical or scientific evidence or evidence-based standards. As expeditiously as possible, but in no event no more than five calendar days after being selected to conduct the external review of the Experimental or Investigational Service, each clinical reviewer must provide to the independent review organization an oral or written opinion on whether the services or treatment

should be covered. If the opinion was not in writing, then within 48 hours after providing that opinion, the clinical reviewer must provide written confirmation of the opinion to the independent review organization.

The independent review organization must reach a decision and notify us, the director and you as expeditiously as your medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review. For Experimental or Investigational Services, the independent review organization must make a decision and provide oral or written notice of its decision within 48 hours after receiving the opinion of each clinical reviewer to us, the director, you and your authorized representative. If the notice was not in writing, then within 48 hours after providing that notice, the independent review organization must provide written confirmation of its decision to us, the director, you and your authorized representative.

The independent review organization is not bound by any decisions or conclusions reached in our utilization review or internal appeal process.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we will immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

If the independent review organization's decision was not in writing, then within 48 hours of rendering its decision, the independent review organization must provide written confirmation of its decision to us, the director and you. The confirmation must include the following information:

- A general description of the reason for the external review request, the date the independent review organization received the assignment from the director, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, the principal reason(s) for its decision, and the rationale for its decision..
- For experimental or investigational treatment reviews, descriptions of the factors considered by the independent review organization in making its decision.

Expedited external review is prohibited for retrospective adverse or final adverse determinations.

Independent Review Organization

All decisions by the independent review organization are deemed as binding on us, and on you to the extent that you have other remedies available under applicable federal or state law.

We will approve coverage if the independent review organization reverses the final adverse decision.

Appeals to the Department of Insurance

Statements informing you and any authorized representative that a standard external review (or Expedited External Review) request deemed to be ineligible for review by us or our representative may be appealed to the director by filing a complaint with the Department of Insurance. To appeal initial determinations of ineligibility for standard external review (or Expedited External Review) please contact:

Illinois Department of Insurance
Office of Consumer Health Insurance
Standard External Review (or Expedited External Review)
320 West Washington Street
Springfield, IL 62767

http://insurance.illinois.gov/Complaints/file_complaint.asp (E-mail)

Toll Free Telephone: (877) 527-9431

You may electronically file your appeal with the Department at http://insurance.illinois.gov/Complaints/file_complaint.asp.

Note: External grievance determinations in most cases are not appealable through the Department of Insurance.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and Certificate of Coverage, the terms of the Certificate of Coverage will control.

The Care24® program integrates elements of traditional employee assistance and work-life programs with health information lines for a comprehensive set of resources. It is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

NurseLine[SM] is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.
Administrative services provided by United HealthCare Services, Inc., or its affiliates.

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Document valid for 2011 COC for Choice, Core or Navigate plans.

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