Disclosure Statement for UnitedHealthcare Plans in Missouri

This Disclosure Statement is not a legal document. For full benefit information please refer to your Certificate of Coverage (COC) and Schedule of Benefits, or contact UnitedHealthcare. In the event of any inconsistency between this statement and your COC, the terms of the COC will prevail.

The following information is provided to members of managed care plans, in addition to the Schedule of Benefits (referred to as Schedule in this notice) which is part of your COC. Please review this information to better understand your health plan benefits and rights.

For questions or information about your health plan or benefit coverage, please call the toll-free member phone number listed on your health plan ID card. You can also contact the Missouri Department of Insurance at **1-573-751-4126**. Please be aware that the Missouri Department of Insurance will not be able to provide specific plan information.

The Managed Care Reform and Patient Rights Act 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 arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in this statement.

Description of coverage

You have purchased a managed care plan. Benefits are payable for covered health services, including hospital and medical care services, that are listed in the Schedule. Please review the Schedule for other important information including Benefit Maximums, Co-payments and Out-of-Pocket maximums.

Exclusions and medical necessity

Your plan contains exclusions and limitations as listed in your Schedule. Exclusions are treatments or services that are not covered by your plan benefits. Limitations are limits to the amount of coverage for certain covered benefits. You will be responsible for any charges that you incur for services that are either excluded or beyond the benefit limitations under your coverage. Please check your COC or Schedule for details.

In order to be covered, treatments or health services must be medically necessary. Medical necessity is determined by UnitedHealthcare and is based on: generally accepted standards of medical practice; clinical appropriateness (i.e., not mainly for your convenience or the convenience of your health care provider); and the treatment or service is not more costly than an alternative that is at least as likely to produce equivalent therapeutic or diagnostic results. Please check your COC for details.

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Prior authorization

We require prior authorization for certain covered health services. Prior authorization means that approval from UnitedHealthcare is required before certain health care services will be covered. The services that require prior authorization are listed in the Schedule within each covered health service category.

In general, network providers are responsible for obtaining prior authorization before they provide these services to you; however, there are some benefits for which you are responsible for obtaining prior authorization. Before receiving any service that requires prior authorization, we recommend contacting us to confirm that approval was granted. You should also verify the current network status of the health care providers and facilities from which you will be obtaining these services. Network facilities and network providers cannot bill you for services they fail to prior authorize as required. To contact us, call the toll-free member telephone number listed on your health plan ID card.

To obtain prior authorization, call the toll-free member telephone number listed 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.

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.

Utilization review

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

Initial determinations on prospective decisions will be made within two working days of obtaining all necessary information regarding a proposed admission, procedure or covered service requiring a review determination. We will notify the provider within 24 hours of making the certification or adverse determination

Concurrent determinations will be made within one working day of obtaining all necessary information. We will notify the provider within one working day of certifying an extended stay or additional service or within 24 hours of an adverse determination.

Retrospective determinations will be made within 30 working days of receiving all necessary information.

If an adverse determination for initial or concurrent is made by us, we will give the provider rendering the service an opportunity to request, on behalf of the enrollee, a reconsideration of the determination. The reconsideration will occur within one working day of the receipt of the request. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee. Further information with respect to appeals can be found below, under the Grievance Procedure section.

You may designate a representative and claim denials will be made by qualified clinical personnel and denial notices will include the basis of our determination.

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 toll-free member telephone number listed on your health plan ID card.

Your financial responsibility

Benefits are available to you only if you are enrolled for coverage under the policy. Your enrolling group may require you to make payments to them in order for you to remain covered under the policy. Your plan may include deductibles, coinsurance, co-payments, caps on payments for certain services and other limitations. You are also responsible for non-covered health care procedures, treatments or services.

Should you receive services from a health care provider who is not part of our network, you may be billed for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the billed service. You can obtain copies of our reimbursement policies for yourself or to share with non-network providers by going to **www.myuhc.com** or by calling the toll-free member telephone number listed on your health plan ID card.

Grievance procedure

A grievance is a written complaint by you or your designee regarding health care services, a utilization review adverse determination, claims or matters pertaining to the contractual relationship between us.

To resolve a question, grievance or appeal contact Customer Care by calling the member telephone number listed on your health plan ID card. Customer care professionals are available during regular business hours, Monday through Friday.

If our representative cannot resolve the issue to your satisfaction over the phone, we can help you prepare and submit a written grievance. You may also designate a representative to submit information for you. We will acknowledge receipt in writing within 10 working days and conduct an investigation. If the investigation is not completed within 20 working days of receipt of the grievance we will notify you or your designee. Our investigation will be completed within 30 working days of the notification.

Within 5 days after the investigation is completed, you or your designee will be notified in writing by someone not involved in the circumstances giving rise to the grievance or the investigation of our decision. At that time you or your designee will also be notified of any right to appeal the decision to a second level for further review, as indicated below. We will also notify you or your designee within 15 days after completion of the investigation.

As indicated above, if you disagree with our decision you can submit a written request for a second review. Upon receipt of the request, we will submit the grievance to an advisory panel. Review will follow the same time frames as indicated above. The panel will advise you in writing of the findings within 15 days of concluding its review.

If you have a dispute about a health care service that if left untreated would seriously jeopardize your life or health or jeopardize your ability to regain maximum function and requires special consideration as an expedited review. If your situation is determined to fall within expedited review criteria, we will verbally notify you of our determination within 72 hours after receipt and within 3 working days in writing.

At any time during this process you have the right to take your matter to the Missouri Department of Insurance. You can contact the Department by calling their consumer complaint hotline at **800-726-7390**.

Emergency services

Emergency services are services that are required to stabilize or initiate treatment for an emergency medical condition. An emergency medical condition is a sudden and at the time unexpected onset of a health condition that manifests itself by symptoms of severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe immediate medical care is required. Emergency services are not subject to prior approval.

Emergency services are not subject to annual deductibles but may include co-payments and coinsurance. If you are admitted to a non-network hospital after you receive outpatient emergency health services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a network hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-network hospital after the date we decide a transfer is medically appropriate, benefits will not be provided.

Accessing or changing primary and specialty care providers

To find a doctor or other health care professional, log into myuhc.com and select the Find a Doctor link. Here you can find information on network providers who can meet your need for primary care, specialty care or mental health care, if applicable. Network 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 co-payment or significantly higher costs to you. **Some plans do not provide benefit coverage for care from physicians or facilities outside of our network.**

Right to obtain a referral

You may obtain a referral for covered services to a non-network provider if we do not have a network provider with appropriate training and experience to meet your particular health care needs. Please call the toll-free member telephone number listed on your health plan ID card if you have any questions.

Unitedhealthcare's member website includes access to our provider directory and other important information regarding your benefits. Visit www.myuhc.com to see whether a physician or hospital is in our network and for other helpful information. Or you can call us at the toll-free member telephone number listed on your health plan ID card.

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