



Medical Necessity: Important changes in your UnitedHealthcare medical benefit plan

UnitedHealthcare is committed to helping people live healthier lives. One way we do this is by promoting high-quality and affordable care. With this in mind, we are introducing a new feature within your medical plan called Medical Necessity. Medical Necessity is aimed at promoting care that is medically appropriate and proven effective.

This document is intended only to highlight this important component of your medical plan. You should refer to your coverage documents (Summary Plan Description, Schedule of Benefits and any attached Riders or Amendments) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage.

Your coverage documents tell you which services are covered benefits under your benefit plan and which services require Prior Authorization.

Prior Authorization

Within your coverage documents you will find a plan requirement called Prior Authorization. Prior Authorization is the process of determining benefit coverage prior to certain services being rendered. A coverage determination is made based on the requirements outlined in your medical plan. This process may include a determination of whether a service, test or procedure is medically necessary and eligible for payment under your plan. In addition, Prior Authorization:

- ▶ Utilizes generally accepted standards of good medical practice in the medical community.
- ▶ Offers communication between you, your health plan and physician on whether a service will be covered by the plan.

How does it work?

Within your benefit coverage documents, you will find a list of services that may require Prior Authorization. And depending on your plan, you may also be required to get a Primary Care Physician (PCP) referral. You or your physician must request that the proposed services be reviewed for coverage. This will allow UnitedHealthcare to review the request and provide a determination of whether the requested service will be covered under your plan.

Generally, when seeking medical services from a network provider — a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network — your network provider will facilitate this process for you. When seeking services from a non-network provider (if applicable), you will be responsible for obtaining Prior Authorization. In addition, if you are in a UnitedHealthcare Options PPO plan, you will be responsible for obtaining Prior Authorization, regardless of whether the service is provided by a network or non-network provider.

We ask that each request for Prior Authorization is submitted at least five business days prior to the scheduled service to provide adequate time for us to review your request.

You and your physician will receive a letter by mail once a determination is made. If the service is approved, you and your physician may proceed with the acknowledgment that the service will be covered. Please review your approval letter carefully so that you understand what services have been authorized and where you can obtain those services.



Please note that the decision is based on whether or not benefits are available under the policy for the proposed treatment or procedure, and thus payable under the policy. Treatment or procedure decisions are between you and your physician.

If a different service is rendered than what was authorized, upon claim receipt the additional services received will be reviewed for coverage under your plan.

If you or your physician do not agree with the determination, a reconsideration or appeal can be requested.

What am I responsible for?

- ▶ **Prior Authorization requirements.** Reference your coverage documents for Prior Authorization requirements. Prior Authorization may apply to network services, non-network services or both, depending on the specific benefit category and your plan. Under most plans, there are situations where you may be responsible for obtaining Prior Authorization for a service. These scenarios are described in more detail in your coverage documents.
- ▶ **Responsibility when using your network benefits.** Network providers are generally responsible for obtaining Prior Authorization from UnitedHealthcare before they provide certain services to you. However, there are some network benefits for which you are responsible for obtaining prior authorization from UnitedHealthcare. In many cases, your network benefits may be reduced if you have not obtained prior authorization from UnitedHealthcare and if review determines service to be not covered under your plan the claim for those services would be denied.
- ▶ **Responsibility when using your non-network benefits.** When you choose to receive certain covered health services from non-network providers, you are responsible for obtaining Prior Authorization from UnitedHealthcare before you receive these services. In many cases, your non-network benefits may be reduced if you have not obtained prior authorization from UnitedHealthcare and if review determines service to be not covered under your plan the claim for those services would be denied.
- ▶ **Wait for a coverage determination.** For services that require Prior Authorization, please wait for a determination before having a planned service performed. In most cases, planned services require you or your physician to submit a request for Prior Authorization five business days before the scheduled service to allow time for the clinical review and coverage determination.
- ▶ **Services determined to be not covered.** If you choose to have a service performed that is determined to be not covered, you will be responsible for all charges. No benefits will be paid.

You may call the member number on the back of your health plan ID card to confirm Prior Authorization requirements, check the status of a determination or ask questions about your determination letter.

How to request Prior Authorization

When you are responsible for obtaining Prior Authorization, you may call the phone number on the back of your health plan ID card. Although your provider may not be required to call, he/she may call, as a courtesy to you, to obtain Prior Authorization on your behalf.

How to find your coverage documents

Your coverage documents tell you which services are covered benefits under your benefit plan and which services require Prior Authorization.

There are several ways to get your coverage documents:

- ▶ **Online:** You may be able to view your coverage documents online at myuhc.com[®]. Click on the “Benefits & Coverage” menu, and then click on “Coverage Documents.”
- ▶ **Print:** If you cannot view your coverage documents online, you can get a free printed copy by asking your employer.



Comparison of current Care Coordination and Prior Authorization process

If you are transitioning to the Prior Authorization process, below is a comparison of our previous Care Coordination with Notification process and our new Prior Authorization process.

Key Processes	Care Coordination with Notification Requirement	Prior Authorization – New
Services that require your network provider to obtain pre-service approval (Notification or Prior Authorization)	Network providers are aware of the services for which they are responsible for providing Notification and are held responsible for notifying UnitedHealthcare.	Network providers are aware of the services for which they are responsible for obtaining Prior Authorization and are held responsible for contacting UnitedHealthcare.
List of services that require you to obtain pre-service approval	Services that require you to provide Notification are outlined in your benefit coverage documents. Members are responsible for notifying UnitedHealthcare.	Services that require you to obtain Prior Authorization are outlined in your benefit coverage documents. Note: You are responsible for requesting Prior Authorization if you are in a UnitedHealthcare Options PPO plan or you are using a non-network provider.
Source for your pre-service requirements	Your benefit coverage documents: Reference your Summary Plan Description, Schedule of Benefits and any attached Riders or Amendments.	No change
Responsibility for Notification/Prior Authorization and liability, if not obtained	Generally, if you are receiving services from network providers, you can rely on your network physician to provide notification. You are responsible for providing notification if the service is being delivered by a non-network provider or if you are in a UnitedHealthcare Options PPO plan. There may be additional requirements specific to your benefit plan. Please refer to your benefit coverage documents.	Generally, if you are receiving services from network providers, you can rely on your network physician to obtain Prior Authorization. You will be responsible for obtaining Prior Authorization if the service is being rendered by a non-network provider or if you are in a UnitedHealthcare Options PPO plan. There may be additional requirements specific to your benefit plan. Please refer to your benefit coverage documents.
Clinical review performed	Coverage review is performed according to your benefit plan. Includes evidence-based clinical reviews to identify plan exclusions including cosmetic, unproven, investigational and experimental procedures.	Coverage review is performed according to your benefit plan. Clinical review is expanded to include use of medical necessity criteria.
Notification of coverage determination	Determination letter is mailed to you with copy to physician.	No change
Liability if service is deemed not covered	Generally, if the service is not covered and you sign an attestation with the physician, you are liable for all charges. Network providers may be held liable if a service requires a coverage determination and that service is performed prior to a non-coverage determination.	No change
Scenarios in which you are held liable for payment	<ul style="list-style-type: none"> ▶ Service requires Notification and you had responsibility for providing Notification, but failed to do so. ▶ Service was deemed not covered and you signed an attestation with your health care provider to be responsible for non-covered charges. ▶ Inpatient bed day was deemed not covered due to custodial determination. 	<ul style="list-style-type: none"> ▶ Service requires Prior Authorization and you had responsibility for obtaining Prior Authorization, but failed to do so. ▶ Service is deemed not covered or not medically necessary by your benefit plan, the determination was communicated before service was delivered and you signed the provider attestation to be responsible for non-covered services. ▶ Inpatient bed day was deemed not covered due to custodial determination.
Appeals process	UnitedHealthcare adheres to all applicable federal and/or state appeal requirements.	No change

Important: This document is not your health plan and is not a part of your coverage documents. The Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments are called your coverage documents. Your coverage documents describe covered health services, your benefits and the rules for using them. If there is any difference between information in this guide and your coverage documents, your coverage documents are the final word on the issue. See the “How to Find Your Coverage Documents” section in this document for more information. Definitions of other important terms used are found in the section at the end of this brochure. List of services that require you to obtain pre-service approval. Services that require you to provide referral are outlined in your benefit coverage documents. Members are responsible for notifying UnitedHealthcare.

Useful Terms

- ▶ **Benefits:** Covered health services available under the group health insurance policy issued by UnitedHealthcare to your employer (also called your Policy). Your right to Benefits is subject to the terms, conditions, limitations and exclusions of that Policy. These are described in your Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments to your Policy.
- ▶ **Benefit Summary:** A high-level overview of the benefits available to you under your Policy.
- ▶ **Coverage Documents:** Documents listing the health care services and costs that are paid for by your health insurance. These documents include the Summary Plan Description, Schedule of Benefits, Riders and/or Amendments which describe your Policy's covered health services and the rules for using them.
- ▶ **Covered Health Services:** Services that your benefit plan has agreed to pay for or reimburse. These are services, supplies or pharmaceutical products that UnitedHealthcare determines are:
 - Medically necessary
 - Described as a covered health service in your Summary Plan Description under Section 1: Covered Health Services and in the Schedule of Benefits; and
 - Not otherwise excluded in your Summary Plan Description under Exclusions and Limitations.

IMPORTANT: The fact that a provider may perform or prescribe a procedure or treatment, or that a treatment may be the only one available for a sickness, injury or illness as defined in your Summary Plan Description does not mean that the treatment is a covered health service. Check your coverage documents to see if a service is covered. If you are not sure, contact Customer Care at the phone number on the back of your health plan ID card for more information.

- ▶ **Facility:** A clinic, office or building like a hospital, outpatient surgical center, laboratory or X-ray unit that provides health care services.
- ▶ **Health Plan ID Card:** The card issued to you by UnitedHealthcare that identifies you as a UnitedHealthcare member. It includes important information like your name, type of health plan and important phone numbers like Customer Care.
- ▶ **Medical Necessity or Medically Necessary:** Health care services or supplies needed to prevent, evaluate, diagnose or treat an illness, injury, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or our designee:
 - Generally Accepted Standards of Medical Practice.
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, substance use disorder, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

- Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com and to physicians and other health care professionals on www.UnitedHealthcareOnline.com.

- ▶ **myuhc.com®:** The website where members can find important information about their UnitedHealthcare plan.
- ▶ **Network Benefits:** Covered health services received from a network provider.
- ▶ **Network Provider:** A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee. Members receive a higher level of benefits when they receive care from a network provider.
- ▶ **Non-Network Provider:** A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from a non-network provider.
- ▶ **Non-Network Benefits:** Covered health services received from a non-network provider.
- ▶ **Prior Authorization:** Getting approval from UnitedHealthcare for the recommended medicine, services or supplies prior to receiving them. Without this prior approval, your health plan may not provide coverage, or pay for the medication, services or supplies. Not all covered health services require Prior Authorization.
- ▶ **Schedule of Benefits:** A document containing a description of how benefits for covered health services will be paid and the member's cost for those services. Part of your coverage documents.
- ▶ **Summary Plan Description:** A listing of the health care services and costs that are paid for by your health insurance plan, which includes a more complete description of the benefits covered under your Policy.

For help understanding any terms used in this document, please visit JustPlainClear.com.

