

Understanding the basics of network vs. non-network benefits and prior authorization



Please read this information carefully to:

- ▶ Understand the basics of network vs. non-network benefits
- ▶ Understand how prior authorization (getting approval before you get services) works
- ▶ Find your coverage documents so you know your health plan details

Important: This document is not your health plan. The Certificate of Coverage, 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 below for more information. Definitions of other important terms used are found in the section at the end of this brochure.

UnitedHealthcare offers benefits through a specific network of health care providers. A provider is a doctor, facility (like a hospital or clinic) or other health care professional that has a contract with UnitedHealthcare or its affiliates to provide covered health services to UnitedHealthcare members. If your health plan includes coverage for both network and non-network providers, with a few exceptions, UnitedHealthcare members receive a higher level of benefits when they receive care from network providers. Depending on your plan, you may have no coverage if you do not use a network provider.

How to Find Network Providers

1. Log in to **myuhc.com**[®]
2. Click on “Find a Doctor”
3. Search by specialty (type of doctor), location, gender (male or female) or languages spoken

How to find your coverage documents

Your coverage documents tell you which services are covered benefits and which services also need prior authorization (pre-approval). For more information, please see the Prior Authorization section.

There are several ways to get your coverage documents:

- ▶ **Online:** Some members can see their coverage documents online at www.myuhc.com. Click on the “Benefits & Coverage” menu, and then click on “Coverage Documents.”
- ▶ **Print:** If you cannot see your coverage documents online, you can get a free printed copy by asking your employer or calling the Customer Care phone number on the back of your health plan ID card. When the voice response system says, “In a few words, please tell me what you are calling about,” say “Certificate of Coverage.” You will then be asked to give your member ID number and date of birth, and confirm your mailing address.



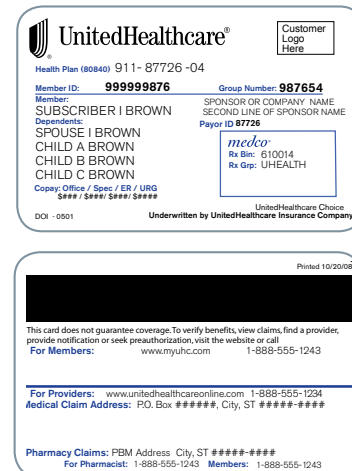
In an emergency, your care is covered at the network benefit level, even if you visit a non-network provider.

Network and non-network benefits

Some UnitedHealthcare plans include both **network** and **non-network** benefits. If you have one of these plans, you can choose to visit either a network or non-network doctor or facility. However, your benefit coverage will be better if you see a network provider.

Some UnitedHealthcare plans only include network benefits. Under these plans, you will be responsible for all charges if you use a non-network provider, except for emergency care. In an emergency, your care is covered at the network benefit level, even if you visit a non-network provider. If you choose to get service from a non-network provider, you should always verify whether that service or treatment is covered under your plan. If you are uncertain, please call the Customer Care number on your health plan ID card.

The chart below describes the difference between network and non-network benefits for different types of services.



Type of service	Network benefits	Non-network benefits (if included in your plan)
Covered health services	Services covered under your coverage documents and given by a network provider	Services covered under your coverage documents but given by a non-network provider
Services provided at hospitals, outpatient* surgery centers or other freestanding facilities (*Outpatient services are those that do not require an overnight stay.)	Facility must be in the network in order to receive network benefits	Non-network benefit level is used if the facility is not in the network
Emergency Health Services	Emergency Health Services are always covered at the network benefit level	Emergency Health Services are always covered at the network benefit level, even if delivered by a non-network provider
Covered health services not available from a network provider	<p>If services are not available in the network, you <u>may</u> be eligible to have these services paid for at the network benefit level, even if you receive the services from a non-network provider.</p> <p>Before you get the services, a network provider must get UnitedHealthcare's approval for payment at the network benefit level. UnitedHealthcare's authorization is based on confirmation that the service is not offered in the network and that the service is eligible for coverage.</p> <p>Either your general doctor (primary care physician) or doctor who provides specific types of services (specialist) can make this request.</p>	<p>If services are not available in the network, you <u>may</u> be eligible to have these services paid for at the network benefit level, even if you receive the services from a non-network provider.</p> <p>Before you get the services, a network provider must get UnitedHealthcare's approval for payment at the network benefit level. UnitedHealthcare's authorization is based on confirmation that the service is not offered in the network and that the service is eligible for coverage.</p> <p>Either your general doctor ("primary care physician") or doctor who provides specific types of services ("specialist") can make this request.</p> <p>The non-network benefit level will apply if UnitedHealthcare determines that a) the service was available from a network provider or b) prior approval was not received.</p>

Note: When you get services from a network provider, remember to show your health plan ID card every time. Otherwise, they may bill you for the entire cost of the services.

Prior authorization

In order to have certain covered health services paid for by your insurance, UnitedHealthcare must approve them before you get treatment. This is called prior authorization. Your coverage documents list the services that require you to obtain **prior authorization** in the Schedule of Benefits and within each covered health service category.

For services to be approved, they must be **medically necessary**, which means that the services are appropriate, cost-efficient and follow **Generally Accepted Standards of Medical Practice as determined by UnitedHealthcare**. For a detailed definition of medically necessary, please see the Useful Terms section at the end of this document.

The chart below describes the difference between prior authorization in network and non-network situations.

Question	Network benefits	Non-network benefits
Who requests prior authorization?	Network providers are responsible for getting prior authorization for most services that require it. However, some services require you to ask for prior authorization. Check your Schedule of Benefits for details.	You are responsible for getting prior authorization, if required, for services from non-network providers. Your Schedule of Benefits shows the services that require prior authorization.
What if prior authorization is not obtained before getting care?	With a few exceptions, if a network provider is responsible for getting prior authorization, but does not get it, they cannot bill you for those services. Exception: if UnitedHealthcare told you that prior authorization was denied, but you still choose to have the service, you can be billed for the full charges. If you are responsible for getting prior authorization but did not do so, a penalty will be applied.	A penalty will be applied if you do not obtain prior authorization for services from a non-network provider. The non-network provider may also bill you for all services.
Will prior authorization be given in writing?	Yes. UnitedHealthcare will send you an approval or denial letter for all services for which a prior authorization is requested. You will not receive a prior authorization letter for basic hospital inpatient care that does not require prior authorization. When your provider contacts us with a request, we give them a Service Reference Number (SRN) to track the case in our system. An SRN does not mean the service is covered or approved. Confirmation of approval or denial will be sent to you and your provider later when a determination has been made.	Yes. UnitedHealthcare will send you an approval or denial letter for all services for which a prior authorization is requested. You will not receive a prior authorization letter for basic hospital inpatient care that does not require prior authorization. When your provider contacts us with a request, we give them a Service Reference Number (SRN) to track the case in our system. An SRN does not mean the service is covered or approved. Confirmation of approval or denial will be sent to you and your provider later when a determination has been made..
Do the services I receive need to match the services approved in the prior authorization?	Yes. If the services are significantly different from those in the prior authorization, coverage will only be for those services which are eligible for coverage and medically necessary.	Yes. If the services are significantly different from those in the prior authorization, coverage will only be for those services which are eligible for coverage and medically necessary.
What if I receive health services that are not medically necessary?	If you choose to get services that are determined to be not medically necessary during prior authorization, you will be responsible for all charges. No benefits will be paid.	If you choose to get services that are determined to be not medically necessary during prior authorization, you will be responsible for all charges. No benefits will be paid.

Always read your prior authorization approval notices

Read your prior authorization notices carefully to understand:

- ▶ What services are approved (examples: number of visits, types of tests)
- ▶ Where the services should be done (examples: in the doctor's office or hospital)
- ▶ Which providers are authorized to give you the services (examples: admitting doctor name, surgeon name, facility)

Prior authorization special issues

- ▶ Special services and treatments - Authorization is required for the following services:
 - Chiropractic services
 - Physical therapy
 - Occupational therapy

Authorization for these services is done by our affiliate, OptumHealth Physical Health, and authorization notices about these services will show the OptumHealth Physical Health name.

- ▶ **Medicare** - Some members have Medicare as their primary insurer. This means that under the terms of the plan, Medicare pays benefits before UnitedHealthcare pays. If you have Medicare as your primary insurer, you do not have to get prior authorization from UnitedHealthcare before receiving covered health services. This is described in the Certificate of Coverage in Section 7: Coordination of Benefits.

- ▶ **Coverage Determination** - If a service does not require prior authorization, your provider can ask for a coverage determination. A coverage determination says whether a service is a covered health service under your benefit plan.

Contact Customer Care if you have questions

If have you questions about covered health services, your benefits, or how to use them, please contact Customer Care at the phone number on your health plan ID card.



Tip: What to do before getting non-emergency health care services:

- ▶ Go to **myuhc.com** or call Customer Care to make sure your provider is in the UnitedHealthcare network.
- ▶ Check with your provider or with Customer Care to make sure that the services have been approved if prior authorization is required.
- ▶ Read your prior authorization letter to make sure that the approved services match those you are waiting to receive.

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 Certificate of Coverage, 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.
- ▶ **Certificate of Coverage:** A listing of the health care services and costs that are paid for by your health insurance plan. This document has a more complete description of the benefits covered under your Policy. The Certificate of Coverage is provided to the employee who is covered under the plan. Part of your coverage documents.
- ▶ **Coverage Documents:** Documents listing the health care services and costs that are paid for by your health insurance. These documents include the Certificate of Coverage, Riders and/or Amendments which describe your Policy's covered health services and the rules for using them.
- ▶ **Covered Health Services:** Services paid for by your health plan. These are services, supplies or pharmaceutical products that UnitedHealthcare determines are:
 - Medically necessary
 - Described as a covered health service in your Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits; and
 - Not otherwise excluded in your Certificate of Coverage under Section 2: 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 Certificate of Coverage 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 place or building like a hospital, outpatient surgical center, laboratory or x-ray unit that provides health care services.
- ▶ **Medical Necessity or Medically Necessary:** Health care services given for preventing, evaluating, diagnosing or treating a sickness, injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or our designee, in accordance with 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.
- ▶ **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.
- ▶ **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 doctor, facility or other health care professional that has a contract with UnitedHealthcare or its affiliates to provide covered health services to UnitedHealthcare members. Members receive a higher level of benefits when they receive care from a network provider.
- ▶ **Non-Network Provider:** A doctor, facility or other health care professional that does not have a contract with UnitedHealthcare or its affiliates to provide covered health services to UnitedHealthcare members.
- ▶ **Non-Network Benefits:** Covered health services received from a non-network provider.
- ▶ **Prior Authorization:** Approval from UnitedHealthcare required before receiving a specific service. 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.

UnitedHealthcare
Insurance Company



Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

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